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: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 2:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/28/2021 Time: 2:49 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 MARGARET MARY COMMUNITY HOSPITAL (15-1329) 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) CRAIG POLKOW
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	28,123	-563,989	0	-32,884	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	56,999	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		45,809		0	10.00
200.00	Total	0	85,122	-518,180	0	-32,884	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	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	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MARGARET MARY COMMUNITY HOSPITAL	15Z329	99915		09/10/2020	N	O	O	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	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line	Description	1.00	Line
	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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	414,191	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 2:49 pm

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

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

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

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

Line	Description	1.00	Line
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

Line	Description	Part A	Part B	Title V	Title XIX	Line
		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

Line	Description	1.00	Line
	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

Line	Description	Name	County	State	Zip Code	CBSA	FTE/Campus	Line
		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 2:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

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

	Financial Data and Reports	Y/N 1.00	Type 2.00	Date 3.00	
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

	Approved Educational Activities	Y/N 1.00	Legal Oper. 2.00	
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 1.00	Date 2.00	Y/N 3.00	Date 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	07/13/2021	Y	07/13/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 2:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 2:49 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2021 2:49 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	18	6,588	101,472.00	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)		18	6,588	101,472.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,562	7,824.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	109,296.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2021 2:49 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)	1,736	76	4,228			1.00
2.00	HMO and other (see instructions)	921	201				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	39	0	39			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)	1,775	76	4,267			7.00
8.00	INTENSIVE CARE UNIT	146	6	326			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	842			13.00
14.00	Total (see instructions)	1,921	82	5,435	0.00	604.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,182	79	3,119	0.00	9.16	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	12.32	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,625	1,793	8,660	0.00	17.55	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	643.68	27.00
28.00	Observation Bed Days		428	1,637			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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/28/2021 2:49 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	526	37	1,459	1.00
2.00	HMO and other (see instructions)			208	90		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	526	37	1,459	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-4 | Date/Time Prepared: 7/28/2021 2:49 pm

Home Health Agency I | PPS

		1.00	
0.00	County	RIPLEY	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	111.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.44	0.00	2.44	5.00
6.00	Direct Nursing Service		2.31	0.00	2.31	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.37	0.00	1.37	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.60	0.00	0.60	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.14	0.00	0.14	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.28	0.00	0.28	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		17140			20.00
20.01			99915			20.01

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	786	185	22	58	1,051	21.00
22.00	Skilled Nursing Visit Charges	132,048	31,080	3,696	9,744	176,568	22.00
23.00	Physical Therapy Visits	341	239	7	27	614	23.00
24.00	Physical Therapy Visit Charges	68,882	48,278	1,414	5,454	124,028	24.00
25.00	Occupational Therapy Visits	140	214	0	22	376	25.00
26.00	Occupational Therapy Visit Charges	30,240	46,224	0	4,752	81,216	26.00
27.00	Speech Pathology Visits	4	11	0	1	16	27.00
28.00	Speech Pathology Visit Charges	872	2,398	0	218	3,488	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	187	-69	0	7	125	31.00
32.00	Home Health Aide Visit Charges	18,513	-6,831	0	693	12,375	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,458	580	29	115	2,182	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	250,555	121,149	5,110	20,861	397,675	35.00
36.00	Total Number of Episodes (standard/non outlier)	133		16	13	162	36.00
37.00	Total Number of Outlier Episodes		34		5	39	37.00
38.00	Total Non-Routine Medical Supply Charges	20,831	-5,725	234	1,750	17,090	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/28/2021 2:49 pm

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	112 N. BUCKEYE ST.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD	IN	47037	2.00

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

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

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

		Sunday from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County		2.00

		Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/28/2021 2:49 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-9 PARTS I THROUGH IV
Hospice CCN: 15-1551 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	8,948	193	1,456	10,597	11.00
12.00	Hospice Inpatient Respite Care	2	0	3	5	12.00
13.00	Hospice General Inpatient Care	4	0	0	4	13.00
14.00	Total Hospice Days	8,954	193	1,459	10,606	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/28/2021 2:49 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.353082	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,090,372	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	26,841,305	6.00
7.00	Medicaid cost (line 1 times line 6)	9,477,182	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,386,810	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,386,810	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	447,114	1,216,127	1,663,241	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	157,868	1,216,127	1,373,995	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	157,868	1,216,127	1,373,995	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,690,912	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	337,904	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	519,853	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,171,059	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,360,839	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,734,834	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,121,644	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,966,616	2,966,616	-46,711	2,919,905	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		872,487	872,487	46,711	919,198	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		5,299,934	5,299,934	-611,984	4,687,950	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	611,984	611,984	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	216,004	13,365,462	13,581,466	-1	13,581,465	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,211,696	11,560,690	18,772,386	370,534	19,142,920	5.00
7.00	00700	OPERATION OF PLANT	0	1,389,855	1,389,855	-136	1,389,719	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	309,182	309,182	0	309,182	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	532,284	15,209	547,493	0	547,493	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	124,448	90,977	215,425	-15,158	200,267	8.00
9.00	00900	HOUSEKEEPING	959,509	375,338	1,334,847	-1,096	1,333,751	9.00
10.00	01000	DIETARY	642,434	459,999	1,102,433	-761,147	341,286	10.00
11.00	01100	CAFETERIA	0	0	0	737,866	737,866	11.00
13.00	01300	NURSING ADMINISTRATION	2,303,245	998,652	3,301,897	-429,804	2,872,093	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	696,236	3,841,815	4,538,051	-33,694	4,504,357	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	788,468	127,627	916,095	0	916,095	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,014,148	1,099,310	3,113,458	403,783	3,517,241	30.00
31.00	03100	INTENSIVE CARE UNIT	300,881	25,279	326,160	-16,059	310,101	31.00
43.00	04300	NURSERY	0	10,271	10,271	663,398	673,669	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,487,724	3,326,060	4,813,784	-2,815,641	1,998,143	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,305,832	245,947	1,551,779	-1,431,921	119,858	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,081,251	9,868,706	12,949,957	-270,004	12,679,953	54.00
60.00	06000	LABORATORY	1,732,403	2,777,052	4,509,455	-55,158	4,454,297	60.00
65.00	06500	RESPIRATORY THERAPY	604,738	137,617	742,355	-55,266	687,089	65.00
66.00	06600	PHYSICAL THERAPY	975,211	39,373	1,014,584	-10,233	1,004,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,061	15,495	339,556	-12,454	327,102	67.00
68.00	06800	SPEECH PATHOLOGY	156,454	1,989	158,443	-581	157,862	68.00
69.00	06900	ELECTROCARDIOLOGY	573,773	292,132	865,905	-17,440	848,465	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,306,740	3,306,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,419,867	1,419,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,205,535	133,039	1,338,574	0	1,338,574	88.00
90.00	09000	CLINIC	1,877,605	924,722	2,802,327	-191,409	2,610,918	90.00
90.01	09001	WOUND CLINC	331,172	195,461	526,633	-185,203	341,430	90.01
90.02	09002	BEHAVIORAL HEALTH	705,842	55,461	761,303	-29	761,274	90.02
91.00	09100	EMERGENCY	2,274,452	2,707,836	4,982,288	-227,173	4,755,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	643,886	64,427	708,313	0	708,313	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	698,871	261,899	960,770	0	960,770	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,768,163	63,855,919	97,624,082	372,581	97,996,663	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,583,622	2,705,689	13,289,311	0	13,289,311	192.00
192.01	19201	PEDIATRICS	686,675	38,758	725,433	0	725,433	192.01
192.02	19202	BROOKVILLE	1,531,236	116,205	1,647,441	0	1,647,441	192.02
192.03	19203	RADIOLOGY - OSGOOD	89,117	0	89,117	0	89,117	192.03
192.04	19204	ENT	89,959	3,935	93,894	0	93,894	192.04
194.00	07950	COMMUNITY RELATIONS	413,686	719,176	1,132,862	-372,581	760,281	194.00
194.01	07951	COMMUNITY BENEFITS	386,180	305,711	691,891	0	691,891	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	41,741	161,504	203,245	0	203,245	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	187,155	24,482	211,637	0	211,637	194.04
194.05	07955	MMHCB RHC	608,897	55,515	664,412	0	664,412	194.05
194.06	07956	FOUNDATION	181,537	196,817	378,354	0	378,354	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	48,567,968	68,183,711	116,751,679	0	116,751,679	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-732,762	2,187,143	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	919,198	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-86,474	4,601,476	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	611,984	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	86,812	13,668,277	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,693,683	15,449,237	5.00
7.00	00700	OPERATION OF PLANT	-36,415	1,353,304	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	309,182	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	547,493	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-189	200,078	8.00
9.00	00900	HOUSEKEEPING	0	1,333,751	9.00
10.00	01000	DIETARY	0	341,286	10.00
11.00	01100	CAFETERIA	-236,695	501,171	11.00
13.00	01300	NURSING ADMINISTRATION	-2,880	2,869,213	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-136,402	4,367,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-17,944	898,151	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-698,451	2,818,790	30.00
31.00	03100	INTENSIVE CARE UNIT	0	310,101	31.00
43.00	04300	NURSERY	0	673,669	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-7,500	1,990,643	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	119,858	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,481,015	11,198,938	54.00
60.00	06000	LABORATORY	0	4,454,297	60.00
65.00	06500	RESPIRATORY THERAPY	0	687,089	65.00
66.00	06600	PHYSICAL THERAPY	-49,608	954,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327,102	67.00
68.00	06800	SPEECH PATHOLOGY	0	157,862	68.00
69.00	06900	ELECTROCARDIOLOGY	-118,857	729,608	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,306,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,419,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	1,338,574	88.00
90.00	09000	CLINIC	-1,164,888	1,446,030	90.00
90.01	09001	WOUND CLINC	0	341,430	90.01
90.02	09002	BEHAVIORAL HEALTH	-311,547	449,727	90.02
91.00	09100	EMERGENCY	-1,550,438	3,204,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	708,313	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	960,770	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,238,936	87,757,727	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,289,311	192.00
192.01	19201	PEDIATRICS	0	725,433	192.01
192.02	19202	BROOKVILLE	0	1,647,441	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	89,117	192.03
192.04	19204	ENT	0	93,894	192.04
194.00	07950	COMMUNITY RELATIONS	0	760,281	194.00
194.01	07951	COMMUNITY BENEFITS	0	691,891	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	194.02
194.03	07953	EMS	0	203,245	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	211,637	194.04
194.05	07955	MMHCB RHC	0	664,412	194.05
194.06	07956	FOUNDATION	-101,335	277,019	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,340,271	106,411,408	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	360,932	376,934	1.00
	0		360,932	376,934	
	B - OB RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	565,948	47,203	1.00
2.00	NURSERY	43.00	613,219	51,146	2.00
	0		1,179,167	98,349	
	C - COMMUNITY RELATIONS				
1.00	ADMINISTRATIVE & GENERAL	5.00	144,790	227,791	1.00
	0		144,790	227,791	
	D - IMPLANTABLE SUPPLIES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,419,867	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	1,419,867	
	E - OFFSITE BUILDING DEPR RECLASS				
1.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	611,984	1.00
	0		0	611,984	
	F - CENTRAL SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,306,740	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	3,306,740	
	G - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	46,711	1.00
	TOTALS		0	46,711	
500.00	Grand Total: Increases		1,684,889	6,088,376	500.00

RECLASSIFICATIONS

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/28/2021 2:49 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	360,932	376,934	0	1.00
	0		360,932	376,934		
	B - OB RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,179,167	98,349	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,179,167	98,349		
	C - COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	194.00	144,790	227,791	0	1.00
	0		144,790	227,791		
	D - IMPLANTABLE SUPPLIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	8,482	0	1.00
2.00	OPERATING ROOM	50.00	0	1,381,926	0	2.00
3.00	CLINIC	90.00	0	8,034	0	3.00
4.00	WOUND CLINC	90.01	0	21,425	0	4.00
	0		0	1,419,867		
	E - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	611,984	9	1.00
	0		0	611,984		
	F - CENTRAL SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,047	0	2.00
3.00	OPERATION OF PLANT	7.00	0	136	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	15,158	0	4.00
5.00	HOUSEKEEPING	9.00	0	1,096	0	5.00
6.00	DIETARY	10.00	0	23,281	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	429,804	0	7.00
8.00	PHARMACY	15.00	0	33,694	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	200,886	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	16,059	0	10.00
11.00	NURSERY	43.00	0	967	0	11.00
12.00	OPERATING ROOM	50.00	0	1,433,715	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	154,405	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	270,004	0	14.00
15.00	LABORATORY	60.00	0	55,158	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	55,266	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	10,233	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	12,454	0	18.00
19.00	SPEECH PATHOLOGY	68.00	0	581	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	17,440	0	20.00
21.00	CLINIC	90.00	0	183,375	0	21.00
22.00	WOUND CLINC	90.01	0	163,778	0	22.00
23.00	BEHAVIORAL HEALTH	90.02	0	29	0	23.00
24.00	EMERGENCY	91.00	0	227,173	0	24.00
	0		0	3,306,740		
	G - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	46,711	9	1.00
	TOTALS		0	46,711		
500.00	Grand Total: Decreases		1,684,889	6,088,376		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,798,684	0	0	0	0	1.00
2.00	Land Improvements	272,044	6,539	0	6,539	0	2.00
3.00	Buildings and Fixtures	80,236,081	66,468	0	66,468	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,245,768	0	0	0	0	5.00
6.00	Movable Equipment	60,149,852	2,429,922	0	2,429,922	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	151,702,429	2,502,929	0	2,502,929	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	151,702,429	2,502,929	0	2,502,929	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,798,684	0	1.00
2.00	Land Improvements	278,583	0	2.00
3.00	Buildings and Fixtures	80,302,549	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	5,245,768	0	5.00
6.00	Movable Equipment	62,579,774	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	154,205,358	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	154,205,358	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,112,231	0	854,385	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	872,487	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,299,934	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	8,284,652	0	854,385	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,966,616	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	872,487	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	5,299,934	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	9,139,037	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/28/2021 2:49 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	NEW CAP REL COSTS-BLDG & FIXT	64,017,783	0	64,017,783	0.415146	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	20,440,797	0	20,440,797	0.132556	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	69,746,778	0	69,746,778	0.452298	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	154,205,358	0	154,205,358	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,065,520	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	919,198	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,601,476	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	611,984	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	8,198,178	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	121,623	0	0	0	2,187,143	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	919,198	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,601,476	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	611,984	2.01
3.00	Total (sum of lines 1-2)	121,623	0	0	0	8,319,801	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/28/2021 2:49 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,313,621			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-235,356	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,339	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/28/2021 2:49 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	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	27.01
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	A	-86,474	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER INCOME	B	86,812	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	OTHER OPERATING - OTHER OPER. - INTE	B	5,842	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER OPERATING - OTHER OPER. - MISC	B	-36,415	OPERATION OF PLANT	7.00	0	35.00
36.00	OTHER OPERATING - OTHER OPER. - LAUN	B	-189	LAUNDRY & LINEN SERVICE	8.00	0	36.00
37.00	OTHER OPERATING - OTHER OPER. - MEDI	B	-17,944	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	OTHER OPERATING - OTHER OPER. - PHYS	B	-49,608	PHYSICAL THERAPY	66.00	0	38.00
40.00	OTHER OPERATING - OTHER OPER. - OUTP	B	-19,712	CLINIC	90.00	0	40.00
41.00	340B OFFSET	A	-136,402	PHARMACY	15.00	0	41.00
43.00	INTEREST OFFSET	A	-732,762	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00	LOBBYING EXPENSE	A	-6,876	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MEDICAL STAFF RETENTION COST	A	-54,779	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	HAF	A	-3,619,830	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	TELEPHONE & TV OFFSET	A	-2,036	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	BOUTIQUE OFFSET	A	-647	RADIOLOGY-DIAGNOSTIC	54.00	0	45.03
45.04	HOSPITALIST OFFSET	A	-1,596	ADULTS & PEDIATRICS	30.00	11	45.04
45.05	MEDICAL STAFF PLACEMENT FEE	A	-16,004	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.07	FOUNDATION GRANT EXPENSE TO HOSPITAL	A	-101,335	FOUNDATION	194.06	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,340,271				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/28/2021 2:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	2,880	2,880	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	872,455	696,855	175,600	0	0	2.00
3.00	50.00	OPERATING ROOM	62,500	7,500	55,000	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,538,368	1,480,368	58,000	0	0	4.00
5.00	60.00	LABORATORY	67,050	0	67,050	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	158,857	118,857	40,000	0	0	6.00
7.00	90.00	CLINIC	1,180,176	1,145,176	35,000	0	0	7.00
8.00	90.02	BEHAVIORAL HEALTH	311,547	311,547	0	0	0	8.00
9.00	91.00	EMERGENCY	3,012,900	1,550,438	1,462,462	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,206,733	5,313,621	1,893,112		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.02	BEHAVIORAL HEALTH	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	2,880	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	696,855	2.00
3.00	50.00	OPERATING ROOM	0	0	0	7,500	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,480,368	4.00
5.00	60.00	LABORATORY	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	118,857	6.00
7.00	90.00	CLINIC	0	0	0	1,145,176	7.00
8.00	90.02	BEHAVIORAL HEALTH	0	0	0	311,547	8.00
9.00	91.00	EMERGENCY	0	0	0	1,550,438	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	5,313,621	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,187,143	2,187,143				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	919,198	0	919,198			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,601,476			4,601,476		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	611,984			0	611,984	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,668,277	9,163	0	19,277	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,449,237	323,775	0	681,182	0	5.00
7.00	00700	OPERATION OF PLANT	1,353,304	381,549	0	802,739	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	309,182	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	547,493	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	200,078	24,321	0	51,168	0	8.00
9.00	00900	HOUSEKEEPING	1,333,751	25,782	0	54,243	0	9.00
10.00	01000	DIETARY	341,286	13,318	0	28,018	0	10.00
11.00	01100	CAFETERIA	501,171	66,818	0	140,576	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,869,213	826	2,119	1,737	1,411	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,245	0	21,555	0	14.00
15.00	01500	PHARMACY	4,367,955	8,175	0	17,198	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	898,151	37,489	0	78,873	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,818,790	198,802	0	418,254	0	30.00
31.00	03100	INTENSIVE CARE UNIT	310,101	18,799	0	39,550	0	31.00
43.00	04300	NURSERY	673,669	9,975	0	20,985	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,990,643	70,648	0	148,634	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,858	19,056	0	40,091	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,198,938	266,878	0	561,478	0	54.00
60.00	06000	LABORATORY	4,454,297	47,098	0	99,089	0	60.00
65.00	06500	RESPIRATORY THERAPY	687,089	36,014	0	75,769	0	65.00
66.00	06600	PHYSICAL THERAPY	954,743	75,412	0	158,657	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	327,102	15,821	0	33,286	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,862	14,454	0	30,410	0	68.00
69.00	06900	ELECTROCARDIOLOGY	729,608	32,617	0	68,622	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,306,740	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,419,867	27,488	0	57,831	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,338,574	0	54,771	0	36,465	88.00
90.00	09000	CLINIC	1,446,030	189,653	0	399,005	0	90.00
90.01	09001	WOUND CLINC	341,430	10,678	0	22,466	0	90.01
90.02	09002	BEHAVIORAL HEALTH	449,727	19,394	0	40,803	0	90.02
91.00	09100	EMERGENCY	3,204,677	120,994	0	254,557	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	708,313	47,911	1,586	100,798	1,056	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	960,770	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,757,727	2,123,153	58,476	4,466,851	38,932	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,289,311	6,131	683,282	12,899	454,916	192.00
192.01	19201	PEDIATRICS	725,433	30,682	0	64,550	0	192.01
192.02	19202	BROOKVILLE	1,647,441	1,435	143,283	3,018	95,395	192.02
192.03	19203	RADIOLOGY - OSGOOD	89,117	0	3,386	0	2,254	192.03
192.04	19204	ENT	93,894	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	760,281	4,101	0	8,628	0	194.00
194.01	07951	COMMUNITY BENEFITS	691,891	16,322	0	34,340	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	203,245	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	211,637	0	0	0	0	194.04
194.05	07955	MMHCB RHC	664,412	0	30,771	0	20,487	194.05
194.06	07956	FOUNDATION	277,019	5,319	0	11,190	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	106,411,408	2,187,143	919,198	4,601,476	611,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,696,717					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,083,879	18,538,073	18,538,073			5.00
7.00	00700	OPERATION OF PLANT	0	2,537,592	535,341	3,072,933		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	309,182	65,226	0	374,408	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	150,781	698,274	147,311	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	35,253	310,820	65,572	50,749	0	8.00
9.00	00900	HOUSEKEEPING	271,801	1,685,577	355,596	53,799	0	9.00
10.00	01000	DIETARY	79,741	462,363	97,542	27,789	0	10.00
11.00	01100	CAFETERIA	102,242	810,807	171,051	139,426	0	11.00
13.00	01300	NURSING ADMINISTRATION	652,443	3,527,749	744,228	1,723	863	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,800	6,709	21,378	0	14.00
15.00	01500	PHARMACY	197,223	4,590,551	968,441	17,058	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223,350	1,237,863	261,145	78,228	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	730,866	4,166,712	879,026	414,832	0	30.00
31.00	03100	INTENSIVE CARE UNIT	85,231	453,681	95,710	39,227	0	31.00
43.00	04300	NURSERY	173,707	878,336	185,297	20,814	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	421,429	2,631,354	555,121	147,418	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,881	214,886	45,333	39,763	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	872,829	12,900,123	2,721,462	556,885	0	54.00
60.00	06000	LABORATORY	490,740	5,091,224	1,074,065	98,279	0	60.00
65.00	06500	RESPIRATORY THERAPY	171,305	970,177	204,672	75,149	0	65.00
66.00	06600	PHYSICAL THERAPY	276,249	1,465,061	309,075	157,359	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,797	468,006	98,732	33,014	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,319	247,045	52,118	30,161	0	68.00
69.00	06900	ELECTROCARDIOLOGY	162,533	993,380	209,567	68,061	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,306,740	697,603	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,505,186	317,540	57,357	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	341,493	1,771,303	373,681	0	22,309	88.00
90.00	09000	CLINIC	531,871	2,566,559	541,452	395,741	0	90.00
90.01	09001	WOUND CLINC	93,811	468,385	98,812	22,282	0	90.01
90.02	09002	BEHAVIORAL HEALTH	199,945	709,869	149,757	40,469	0	90.02
91.00	09100	EMERGENCY	644,286	4,224,514	891,220	252,475	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	182,394	1,042,058	219,837	99,973	646	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	197,970	1,158,740	244,452	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,545,369	81,973,990	13,382,694	2,939,409	23,818	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,998,040	17,444,579	3,680,144	12,793	278,315	192.00
192.01	19201	PEDIATRICS	194,515	1,015,180	214,166	64,022	0	192.01
192.02	19202	BROOKVILLE	433,755	2,324,327	490,349	2,994	58,362	192.02
192.03	19203	RADIOLOGY - OSGOOD	25,244	120,001	25,316	0	1,379	192.03
192.04	19204	ENT	25,483	119,377	25,184	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	76,170	849,180	179,146	8,557	0	194.00
194.01	07951	COMMUNITY BENEFITS	109,394	851,947	179,730	34,059	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	11,824	215,069	45,372	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	53,016	264,653	55,832	0	0	194.04
194.05	07955	MMHCB RHC	172,483	888,153	187,368	0	12,534	194.05
194.06	07956	FOUNDATION	51,424	344,952	72,772	11,099	0	194.06
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,696,717	106,411,408	18,538,073	3,072,933	374,408	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	845,585					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	8,668	435,809				8.00
9.00	00900	HOUSEKEEPING	9,189	102,960	2,207,121			9.00
10.00	01000	DIETARY	4,747	425	18,957	611,823		10.00
11.00	01100	CAFETERIA	23,815	2,131	95,112	0	1,242,342	11.00
13.00	01300	NURSING ADMINISTRATION	1,254	0	1,175	0	29,026	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,652	0	14,584	0	0	14.00
15.00	01500	PHARMACY	2,914	0	11,636	0	34,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,362	0	53,364	0	81,386	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,856	90,170	282,984	579,888	191,038	30.00
31.00	03100	INTENSIVE CARE UNIT	6,700	3,672	26,759	31,935	20,130	31.00
43.00	04300	NURSERY	3,555	18,480	14,198	0	40,413	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,180	49,095	100,564	0	112,700	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,792	2,992	27,125	0	8,337	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,120	56,124	379,889	0	104,312	54.00
60.00	06000	LABORATORY	16,787	0	67,042	0	145,539	60.00
65.00	06500	RESPIRATORY THERAPY	12,836	2,880	51,264	0	39,142	65.00
66.00	06600	PHYSICAL THERAPY	26,878	5,323	107,345	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,639	18,913	22,521	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,152	2,717	20,575	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,625	7,718	46,429	0	37,109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,797	7,728	39,127	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,067	0	0	0	88.00
90.00	09000	CLINIC	67,595	13,229	269,961	0	0	90.00
90.01	09001	WOUND CLINC	3,806	872	15,200	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	6,912	0	27,607	0	38,126	90.02
91.00	09100	EMERGENCY	43,124	28,574	172,230	0	153,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	17,795	0	71,069	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	503,750	415,070	1,936,717	611,823	1,036,107	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	242,359	8,562	188,046	0	121,189	192.00
192.01	19201	PEDIATRICS	10,935	0	43,674	0	30,755	192.01
192.02	19202	BROOKVILLE	65,425	6,195	2,042	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	176	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	1,462	0	5,837	0	15,199	194.00
194.01	07951	COMMUNITY BENEFITS	5,817	0	23,234	0	24,960	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	4,321	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	13,941	5,806	0	0	0	194.05
194.06	07956	FOUNDATION	1,896	0	7,571	0	9,811	194.06
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)	845,585	435,809	2,207,121	611,823	1,242,342	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	4,306,018					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,123				14.00
15.00	01500	PHARMACY	196,319	0	5,821,791			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,725,348		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,074,872	0	0	1,135,098	8,885,476	30.00
31.00	03100	INTENSIVE CARE UNIT	113,215	0	0	0	791,029	31.00
43.00	04300	NURSERY	227,283	0	0	0	1,388,376	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	127,131	3,748,563	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,942	0	0	0	392,170	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,990	0	0	231,560	17,632,465	54.00
60.00	06000	LABORATORY	818,714	0	0	0	7,311,650	60.00
65.00	06500	RESPIRATORY THERAPY	220,284	0	0	0	1,576,404	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,071,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	646,825	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	357,768	68.00
69.00	06900	ELECTROCARDIOLOGY	155,001	0	0	13,621	1,542,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78,123	0	0	4,082,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,936,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,821,791	0	5,821,791	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,168,360	88.00
90.00	09000	CLINIC	0	0	0	63,565	3,918,102	90.00
90.01	09001	WOUND CLINC	0	0	0	0	609,357	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	972,740	90.02
91.00	09100	EMERGENCY	866,398	0	0	140,752	6,773,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	1,451,378	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,403,192	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,306,018	78,123	5,821,791	1,711,727	75,481,663	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	13,621	21,989,608	192.00
192.01	19201	PEDIATRICS	0	0	0	0	1,378,732	192.01
192.02	19202	BROOKVILLE	0	0	0	0	2,949,694	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	146,872	192.03
192.04	19204	ENT	0	0	0	0	144,561	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	1,059,381	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	1,119,747	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	264,762	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	320,485	194.04
194.05	07955	MMHCB RHC	0	0	0	0	1,107,802	194.05
194.06	07956	FOUNDATION	0	0	0	0	448,101	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,306,018	78,123	5,821,791	1,725,348	106,411,408	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE			7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	8,885,476	30.00
31.00	03100	INTENSIVE CARE UNIT	0	791,029	31.00
43.00	04300	NURSERY	0	1,388,376	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	3,748,563	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	392,170	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,632,465	54.00
60.00	06000	LABORATORY	0	7,311,650	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,576,404	65.00
66.00	06600	PHYSICAL THERAPY	0	2,071,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	646,825	67.00
68.00	06800	SPEECH PATHOLOGY	0	357,768	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,542,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,082,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,936,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,821,791	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	2,168,360	88.00
90.00	09000	CLINIC	0	3,918,102	90.00
90.01	09001	WOUND CLINC	0	609,357	90.01
90.02	09002	BEHAVIORAL HEALTH	0	972,740	90.02
91.00	09100	EMERGENCY	0	6,773,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	1,451,378	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	1,403,192	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	75,481,663	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,989,608	192.00
192.01	19201	PEDIATRICS	0	1,378,732	192.01
192.02	19202	BROOKVILLE	0	2,949,694	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	146,872	192.03
192.04	19204	ENT	0	144,561	192.04
194.00	07950	COMMUNITY RELATIONS	0	1,059,381	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,119,747	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	194.02
194.03	07953	EMS	0	264,762	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	320,485	194.04
194.05	07955	MMHCB RHC	0	1,107,802	194.05
194.06	07956	FOUNDATION	0	448,101	194.06
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	106,411,408	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,163	0	19,277	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	323,775	0	681,182	0	5.00
7.00	00700	OPERATION OF PLANT	0	381,549	0	802,739	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,321	0	51,168	0	8.00
9.00	00900	HOUSEKEEPING	0	25,782	0	54,243	0	9.00
10.00	01000	DIETARY	0	13,318	0	28,018	0	10.00
11.00	01100	CAFETERIA	0	66,818	0	140,576	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	826	2,119	1,737	1,411	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,245	0	21,555	0	14.00
15.00	01500	PHARMACY	0	8,175	0	17,198	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,489	0	78,873	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	198,802	0	418,254	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,799	0	39,550	0	31.00
43.00	04300	NURSERY	0	9,975	0	20,985	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	70,648	0	148,634	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,056	0	40,091	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	266,878	0	561,478	0	54.00
60.00	06000	LABORATORY	0	47,098	0	99,089	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,014	0	75,769	0	65.00
66.00	06600	PHYSICAL THERAPY	0	75,412	0	158,657	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,821	0	33,286	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,454	0	30,410	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,617	0	68,622	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	27,488	0	57,831	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	54,771	0	36,465	88.00
90.00	09000	CLINIC	0	189,653	0	399,005	0	90.00
90.01	09001	WOUND CLINC	0	10,678	0	22,466	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	19,394	0	40,803	0	90.02
91.00	09100	EMERGENCY	0	120,994	0	254,557	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	47,911	1,586	100,798	1,056	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,123,153	58,476	4,466,851	38,932	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,131	683,282	12,899	454,916	192.00
192.01	19201	PEDIATRICS	0	30,682	0	64,550	0	192.01
192.02	19202	BROOKVILLE	0	1,435	143,283	3,018	95,395	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	3,386	0	2,254	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	4,101	0	8,628	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	16,322	0	34,340	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	30,771	0	20,487	194.05
194.06	07956	FOUNDATION	0	5,319	0	11,190	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,187,143	919,198	4,601,476	611,984	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,440	28,440				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,004,957	4,326	1,009,283			5.00
7.00	00700	OPERATION OF PLANT	1,184,288	0	29,147	1,213,435		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	3,551	0	3,551	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	313	8,020	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	75,489	73	3,570	20,040	0	8.00
9.00	00900	HOUSEKEEPING	80,025	564	19,361	21,244	0	9.00
10.00	01000	DIETARY	41,336	166	5,311	10,973	0	10.00
11.00	01100	CAFETERIA	207,394	212	9,313	55,056	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,093	1,354	40,520	680	8	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,800	0	365	8,442	0	14.00
15.00	01500	PHARMACY	25,373	409	52,727	6,736	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,362	464	14,218	30,890	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	617,056	1,517	47,859	163,808	0	30.00
31.00	03100	INTENSIVE CARE UNIT	58,349	177	5,211	15,490	0	31.00
43.00	04300	NURSERY	30,960	361	10,089	8,219	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,282	875	30,224	58,212	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,147	74	2,468	15,702	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,356	1,812	148,171	219,902	0	54.00
60.00	06000	LABORATORY	146,187	1,019	58,478	38,808	0	60.00
65.00	06500	RESPIRATORY THERAPY	111,783	356	11,143	29,675	0	65.00
66.00	06600	PHYSICAL THERAPY	234,069	573	16,828	62,138	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,107	191	5,376	13,036	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,864	92	2,838	11,910	0	68.00
69.00	06900	ELECTROCARDIOLOGY	101,239	337	11,410	26,876	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	37,981	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	85,319	0	17,289	22,649	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	91,236	709	20,345	0	212	88.00
90.00	09000	CLINIC	588,658	1,104	29,479	156,270	0	90.00
90.01	09001	WOUND CLINC	33,144	195	5,380	8,799	0	90.01
90.02	09002	BEHAVIORAL HEALTH	60,197	415	8,154	15,980	0	90.02
91.00	09100	EMERGENCY	375,551	1,337	48,523	99,697	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	151,351	379	11,969	39,477	6	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	411	13,309	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,687,412	19,815	728,627	1,160,709	226	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,157,228	6,231	200,338	5,052	2,639	192.00
192.01	19201	PEDIATRICS	95,232	404	11,660	25,281	0	192.01
192.02	19202	BROOKVILLE	243,131	900	26,697	1,182	554	192.02
192.03	19203	RADIOLOGY - OSGOOD	5,640	52	1,378	0	13	192.03
192.04	19204	ENT	0	53	1,371	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	12,729	158	9,754	3,379	0	194.00
194.01	07951	COMMUNITY BENEFITS	50,662	227	9,785	13,449	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	25	2,470	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	110	3,040	0	0	194.04
194.05	07955	MMHCB RHC	51,258	358	10,201	0	119	194.05
194.06	07956	FOUNDATION	16,509	107	3,962	4,383	0	194.06
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,319,801	28,440	1,009,283	1,213,435	3,551	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	8,333					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	85	99,257				8.00
9.00	00900	HOUSEKEEPING	91	23,449	144,734			9.00
10.00	01000	DIETARY	47	97	1,243	59,173		10.00
11.00	01100	CAFETERIA	235	485	6,237	0	278,932	11.00
13.00	01300	NURSING ADMINISTRATION	12	0	77	0	6,517	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36	0	956	0	0	14.00
15.00	01500	PHARMACY	29	0	763	0	7,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132	0	3,499	0	18,273	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	698	20,537	18,557	56,084	42,889	30.00
31.00	03100	INTENSIVE CARE UNIT	66	836	1,755	3,089	4,520	31.00
43.00	04300	NURSERY	35	4,209	931	0	9,074	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	248	11,182	6,595	0	25,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67	682	1,779	0	1,872	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937	12,782	24,912	0	23,420	54.00
60.00	06000	LABORATORY	165	0	4,396	0	32,677	60.00
65.00	06500	RESPIRATORY THERAPY	126	656	3,362	0	8,788	65.00
66.00	06600	PHYSICAL THERAPY	265	1,212	7,039	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	56	4,307	1,477	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	51	619	1,349	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	115	1,758	3,045	0	8,332	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	97	1,760	2,566	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	243	0	0	0	88.00
90.00	09000	CLINIC	666	3,013	17,703	0	0	90.00
90.01	09001	WOUND CLINC	38	199	997	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	68	0	1,810	0	8,560	90.02
91.00	09100	EMERGENCY	425	6,508	11,294	0	34,571	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	175	0	4,660	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,965	94,534	127,002	59,173	232,627	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,388	1,950	12,331	0	27,210	192.00
192.01	19201	PEDIATRICS	108	0	2,864	0	6,905	192.01
192.02	19202	BROOKVILLE	645	1,411	134	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	40	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	14	0	383	0	3,413	194.00
194.01	07951	COMMUNITY BENEFITS	57	0	1,524	0	5,604	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	970	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	137	1,322	0	0	0	194.05
194.06	07956	FOUNDATION	19	0	496	0	2,203	194.06
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)	8,333	99,257	144,734	59,173	278,932	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	55,261					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,599				14.00
15.00	01500	PHARMACY	2,519	0	96,386			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	183,838		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,795	0	0	120,947	1,103,747	30.00
31.00	03100	INTENSIVE CARE UNIT	1,453	0	0	0	90,946	31.00
43.00	04300	NURSERY	2,917	0	0	0	66,795	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,546	365,468	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	602	0	0	0	82,393	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,533	0	0	24,673	1,292,498	54.00
60.00	06000	LABORATORY	10,507	0	0	0	292,237	60.00
65.00	06500	RESPIRATORY THERAPY	2,827	0	0	0	168,716	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	322,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	73,550	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	61,723	68.00
69.00	06900	ELECTROCARDIOLOGY	1,989	0	0	1,451	156,552	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,599	0	0	79,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	129,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	96,386	0	96,386	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	112,745	88.00
90.00	09000	CLINIC	0	0	0	6,773	803,666	90.00
90.01	09001	WOUND CLINC	0	0	0	0	48,752	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	95,184	90.02
91.00	09100	EMERGENCY	11,119	0	0	14,997	604,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	208,017	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	13,720	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,261	41,599	96,386	182,387	6,268,501	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,451	1,416,818	192.00
192.01	19201	PEDIATRICS	0	0	0	0	142,454	192.01
192.02	19202	BROOKVILLE	0	0	0	0	274,654	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	7,123	192.03
192.04	19204	ENT	0	0	0	0	1,424	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	29,830	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	81,308	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	3,465	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	3,150	194.04
194.05	07955	MMHCB RHC	0	0	0	0	63,395	194.05
194.06	07956	FOUNDATION	0	0	0	0	27,679	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,261	41,599	96,386	183,838	8,319,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE			7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,103,747	30.00
31.00	03100	INTENSIVE CARE UNIT	0	90,946	31.00
43.00	04300	NURSERY	0	66,795	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	365,468	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	82,393	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,292,498	54.00
60.00	06000	LABORATORY	0	292,237	60.00
65.00	06500	RESPIRATORY THERAPY	0	168,716	65.00
66.00	06600	PHYSICAL THERAPY	0	322,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	73,550	67.00
68.00	06800	SPEECH PATHOLOGY	0	61,723	68.00
69.00	06900	ELECTROCARDIOLOGY	0	156,552	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	129,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,386	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	112,745	88.00
90.00	09000	CLINIC	0	803,666	90.00
90.01	09001	WOUND CLINC	0	48,752	90.01
90.02	09002	BEHAVIORAL HEALTH	0	95,184	90.02
91.00	09100	EMERGENCY	0	604,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	208,017	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	13,720	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,268,501	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,416,818	192.00
192.01	19201	PEDIATRICS	0	142,454	192.01
192.02	19202	BROOKVILLE	0	274,654	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	7,123	192.03
192.04	19204	ENT	0	1,424	192.04
194.00	07950	COMMUNITY RELATIONS	0	29,830	194.00
194.01	07951	COMMUNITY BENEFITS	0	81,308	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	194.02
194.03	07953	EMS	0	3,465	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	3,150	194.04
194.05	07955	MMHCB RHC	0	63,395	194.05
194.06	07956	FOUNDATION	0	27,679	194.06
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,319,801	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	161,603					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	86,330				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			161,603			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	86,330		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	677	0	677	0	48,351,964	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,923	0	23,923	0	7,356,486	5.00
7.00	00700	OPERATION OF PLANT	28,192	0	28,192	0	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	532,284	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,797	0	1,797	0	124,448	8.00
9.00	00900	HOUSEKEEPING	1,905	0	1,905	0	959,509	9.00
10.00	01000	DIETARY	984	0	984	0	281,502	10.00
11.00	01100	CAFETERIA	4,937	0	4,937	0	360,932	11.00
13.00	01300	NURSING ADMINISTRATION	61	199	61	199	2,303,245	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757	0	757	0	0	14.00
15.00	01500	PHARMACY	604	0	604	0	696,236	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	0	2,770	0	788,468	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,689	0	14,689	0	2,580,096	30.00
31.00	03100	INTENSIVE CARE UNIT	1,389	0	1,389	0	300,881	31.00
43.00	04300	NURSERY	737	0	737	0	613,219	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,220	0	5,220	0	1,487,724	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,408	0	1,408	0	126,665	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,719	0	19,719	0	3,081,251	54.00
60.00	06000	LABORATORY	3,480	0	3,480	0	1,732,403	60.00
65.00	06500	RESPIRATORY THERAPY	2,661	0	2,661	0	604,738	65.00
66.00	06600	PHYSICAL THERAPY	5,572	0	5,572	0	975,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,169	0	1,169	0	324,061	67.00
68.00	06800	SPEECH PATHOLOGY	1,068	0	1,068	0	156,454	68.00
69.00	06900	ELECTROCARDIOLOGY	2,410	0	2,410	0	573,773	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,031	0	2,031	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,144	0	5,144	1,205,535	88.00
90.00	09000	CLINIC	14,013	0	14,013	0	1,877,605	90.00
90.01	09001	WOUND CLINC	789	0	789	0	331,172	90.01
90.02	09002	BEHAVIORAL HEALTH	1,433	0	1,433	0	705,842	90.02
91.00	09100	EMERGENCY	8,940	0	8,940	0	2,274,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,540	149	3,540	149	643,886	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	698,871	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,875	5,492	156,875	5,492	33,696,949	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	453	64,173	453	64,173	10,583,622	192.00
192.01	19201	PEDIATRICS	2,267	0	2,267	0	686,675	192.01
192.02	19202	BROOKVILLE	106	13,457	106	13,457	1,531,236	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	318	0	318	89,117	192.03
192.04	19204	ENT	0	0	0	0	89,959	192.04
194.00	07950	COMMUNITY RELATIONS	303	0	303	0	268,896	194.00
194.01	07951	COMMUNITY BENEFITS	1,206	0	1,206	0	386,180	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	41,741	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	187,155	194.04
194.05	07955	MMHCB RHC	0	2,890	0	2,890	608,897	194.05
194.06	07956	FOUNDATION	393	0	393	0	181,537	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,187,143	919,198	4,601,476	611,984	13,696,717	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.534049	10.647492	28.473952	7.088891	0.283271	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					28,440	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 2:49 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	2.00	2.01	4.00	
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000588	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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,538,073	87,873,335				5.00
7.00	00700	OPERATION OF PLANT	0	2,537,592	108,811			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	309,182	0	86,330		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	698,274	0	0	175,296	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	310,820	1,797	0	1,797	8.00
9.00	00900	HOUSEKEEPING	0	1,685,577	1,905	0	1,905	9.00
10.00	01000	DIETARY	0	462,363	984	0	984	10.00
11.00	01100	CAFETERIA	0	810,807	4,937	0	4,937	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,527,749	61	199	260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,800	757	0	757	14.00
15.00	01500	PHARMACY	0	4,590,551	604	0	604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,237,863	2,770	0	2,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,166,712	14,689	0	14,689	30.00
31.00	03100	INTENSIVE CARE UNIT	0	453,681	1,389	0	1,389	31.00
43.00	04300	NURSERY	0	878,336	737	0	737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,631,354	5,220	0	5,220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	214,886	1,408	0	1,408	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,900,123	19,719	0	19,719	54.00
60.00	06000	LABORATORY	0	5,091,224	3,480	0	3,480	60.00
65.00	06500	RESPIRATORY THERAPY	0	970,177	2,661	0	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,465,061	5,572	0	5,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	468,006	1,169	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	247,045	1,068	0	1,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	993,380	2,410	0	2,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,306,740	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,505,186	2,031	0	2,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,771,303	0	5,144	0	88.00
90.00	09000	CLINIC	0	2,566,559	14,013	0	14,013	90.00
90.01	09001	WOUND CLINC	0	468,385	789	0	789	90.01
90.02	09002	BEHAVIORAL HEALTH	0	709,869	1,433	0	1,433	90.02
91.00	09100	EMERGENCY	0	4,224,514	8,940	0	8,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,042,058	3,540	149	3,689	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,158,740	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,538,073	63,435,917	104,083	5,492	104,431	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,444,579	453	64,173	50,243	192.00
192.01	19201	PEDIATRICS	0	1,015,180	2,267	0	2,267	192.01
192.02	19202	BROOKVILLE	0	2,324,327	106	13,457	13,563	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	120,001	0	318	0	192.03
192.04	19204	ENT	0	119,377	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	849,180	303	0	303	194.00
194.01	07951	COMMUNITY BENEFITS	0	851,947	1,206	0	1,206	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	215,069	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	264,653	0	0	0	194.04
194.05	07955	MMHCB RHC	0	888,153	0	2,890	2,890	194.05
194.06	07956	FOUNDATION	0	344,952	393	0	393	194.06
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)		18,538,073	3,072,933	374,408	845,585	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.210964	28.241014	4.336940	4.823755	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,009,283	1,213,435	3,551	8,333	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.011486	11.151768	0.041133	0.047537	205.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	311,522					8.00
9.00	00900	HOUSEKEEPING	73,597	114,566				9.00
10.00	01000	DIETARY	304	984	15,250			10.00
11.00	01100	CAFETERIA	1,523	4,937	0	24,439		11.00
13.00	01300	NURSING ADMINISTRATION	0	61	0	571	313,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	757	0	0	0	14.00
15.00	01500	PHARMACY	0	604	0	686	14,278	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,770	0	1,601	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,455	14,689	14,454	3,758	78,174	30.00
31.00	03100	INTENSIVE CARE UNIT	2,625	1,389	796	396	8,234	31.00
43.00	04300	NURSERY	13,210	737	0	795	16,530	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,094	5,220	0	2,217	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,139	1,408	0	164	3,414	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,118	19,719	0	2,052	42,691	54.00
60.00	06000	LABORATORY	0	3,480	0	2,863	59,544	60.00
65.00	06500	RESPIRATORY THERAPY	2,059	2,661	0	770	16,021	65.00
66.00	06600	PHYSICAL THERAPY	3,805	5,572	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,519	1,169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,942	1,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,517	2,410	0	730	11,273	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,524	2,031	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	763	0	0	0	0	88.00
90.00	09000	CLINIC	9,456	14,013	0	0	0	90.00
90.01	09001	WOUND CLINC	623	789	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	1,433	0	750	0	90.02
91.00	09100	EMERGENCY	20,425	8,940	0	3,029	63,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,689	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	296,698	100,530	15,250	20,382	313,171	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,120	9,761	0	2,384	0	192.00
192.01	19201	PEDIATRICS	0	2,267	0	605	0	192.01
192.02	19202	BROOKVILLE	4,428	106	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	126	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	303	0	299	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,206	0	491	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	85	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	4,150	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	393	0	193	0	194.06
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)	435,809	2,207,121	611,823	1,242,342	4,306,018	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.398967	19.265061	40.119541	50.834404	13.749734	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	99,257	144,734	59,173	278,932	55,261	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.318620	1.263324	3.880197	11.413397	0.176456	205.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 7/28/2021 2:49 pm

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 2:49 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	500		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	56		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	102		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	28		90.00
90.01	09001	WOUND CLINC	0	0	0		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	62		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	754		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6		192.00
192.01	19201	PEDIATRICS	0	0	0		192.01
192.02	19202	BROOKVILLE	0	0	0		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0		192.03
192.04	19204	ENT	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0		194.02
194.03	07953	EMS	0	0	0		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0		194.04
194.05	07955	MMHCB RHC	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0		194.06
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)	78,123	5,821,791	1,725,348		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	781.230000	58,217.910000	2,270.194737		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,599	96,386	183,838		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	415.990000	963.860000	241.892105		205.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 7/28/2021 2:49 pm

	Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		14.00	15.00	16.00		
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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,885,476		8,885,476	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	791,029		791,029	0	0	31.00
43.00	04300	NURSERY	1,388,376		1,388,376	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,748,563		3,748,563	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,170		392,170	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,632,465		17,632,465	0	0	54.00
60.00	06000	LABORATORY	7,311,650		7,311,650	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,576,404	0	1,576,404	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,071,041	0	2,071,041	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	646,825	0	646,825	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	357,768	0	357,768	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,542,511		1,542,511	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,082,466		4,082,466	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,936,735		1,936,735	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,821,791		5,821,791	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,168,360		2,168,360	0	0	88.00
90.00	09000	CLINIC	3,918,102		3,918,102	0	0	90.00
90.01	09001	WOUND CLINC	609,357		609,357	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	972,740		972,740	0	0	90.02
91.00	09100	EMERGENCY	6,773,264		6,773,264	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,463,669		2,463,669		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,451,378		1,451,378		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,403,192		1,403,192		0	116.00
200.00		Subtotal (see instructions)	77,945,332	0	77,945,332	0	0	200.00
201.00		Less Observation Beds	2,463,669		2,463,669		0	201.00
202.00		Total (see instructions)	75,481,663	0	75,481,663	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,486,777		5,486,777			30.00
31.00	03100	INTENSIVE CARE UNIT	795,618		795,618			31.00
43.00	04300	NURSERY	2,274,179		2,274,179			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,921,148	5,965,059	7,886,207	0.475332	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,896	45,189	279,085	1.405199	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,509,230	77,574,958	79,084,188	0.222958	0.000000	54.00
60.00	06000	LABORATORY	3,551,692	37,864,453	41,416,145	0.176541	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,410,093	1,303,800	3,713,893	0.424461	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	182,052	4,067,101	4,249,153	0.487401	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,699	1,060,369	1,195,068	0.541245	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,756	560,951	610,707	0.585826	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	274,278	4,564,545	4,838,823	0.318778	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,822,579	10,293,977	14,116,556	0.289197	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,062,414	1,583,407	2,645,821	0.731998	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,769,610	10,601,954	15,371,564	0.378738	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,452,922	1,452,922			88.00
90.00	09000	CLINIC	0	6,104,664	6,104,664	0.641821	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,395,185	1,395,185	0.436757	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	335	593,362	593,697	1.638445	0.000000	90.02
91.00	09100	EMERGENCY	471,823	13,924,217	14,396,040	0.470495	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,033	3,185,556	3,263,589	0.754896	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	570,058	570,058			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,039,277	2,039,277			116.00
200.00		Subtotal (see instructions)	29,028,212	184,751,004	213,779,216			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,028,212	184,751,004	213,779,216			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINC	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,885,476		8,885,476	0	8,885,476	30.00
31.00	03100	INTENSIVE CARE UNIT	791,029		791,029	0	791,029	31.00
43.00	04300	NURSERY	1,388,376		1,388,376	0	1,388,376	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,748,563		3,748,563	0	3,748,563	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,170		392,170	0	392,170	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,632,465		17,632,465	0	17,632,465	54.00
60.00	06000	LABORATORY	7,311,650		7,311,650	0	7,311,650	60.00
65.00	06500	RESPIRATORY THERAPY	1,576,404	0	1,576,404	0	1,576,404	65.00
66.00	06600	PHYSICAL THERAPY	2,071,041	0	2,071,041	0	2,071,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	646,825	0	646,825	0	646,825	67.00
68.00	06800	SPEECH PATHOLOGY	357,768	0	357,768	0	357,768	68.00
69.00	06900	ELECTROCARDIOLOGY	1,542,511		1,542,511	0	1,542,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,082,466		4,082,466	0	4,082,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,936,735		1,936,735	0	1,936,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,821,791		5,821,791	0	5,821,791	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,168,360		2,168,360	0	2,168,360	88.00
90.00	09000	CLINIC	3,918,102		3,918,102	0	3,918,102	90.00
90.01	09001	WOUND CLINC	609,357		609,357	0	609,357	90.01
90.02	09002	BEHAVIORAL HEALTH	972,740		972,740	0	972,740	90.02
91.00	09100	EMERGENCY	6,773,264		6,773,264	0	6,773,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,463,669		2,463,669		2,463,669	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,451,378		1,451,378		1,451,378	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,403,192		1,403,192		1,403,192	116.00
200.00		Subtotal (see instructions)	77,945,332	0	77,945,332	0	77,945,332	200.00
201.00		Less Observation Beds	2,463,669		2,463,669		2,463,669	201.00
202.00		Total (see instructions)	75,481,663	0	75,481,663	0	75,481,663	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Charges 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	5,486,777		5,486,777			30.00
31.00	03100	INTENSIVE CARE UNIT	795,618		795,618			31.00
43.00	04300	NURSERY	2,274,179		2,274,179			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,921,148	5,965,059	7,886,207	0.475332	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,896	45,189	279,085	1.405199	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,509,230	77,574,958	79,084,188	0.222958	0.000000	54.00
60.00	06000	LABORATORY	3,551,692	37,864,453	41,416,145	0.176541	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,410,093	1,303,800	3,713,893	0.424461	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	182,052	4,067,101	4,249,153	0.487401	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,699	1,060,369	1,195,068	0.541245	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,756	560,951	610,707	0.585826	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	274,278	4,564,545	4,838,823	0.318778	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,822,579	10,293,977	14,116,556	0.289197	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,062,414	1,583,407	2,645,821	0.731998	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,769,610	10,601,954	15,371,564	0.378738	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,452,922	1,452,922	1.492413	0.000000	88.00
90.00	09000	CLINIC	0	6,104,664	6,104,664	0.641821	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,395,185	1,395,185	0.436757	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	335	593,362	593,697	1.638445	0.000000	90.02
91.00	09100	EMERGENCY	471,823	13,924,217	14,396,040	0.470495	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,033	3,185,556	3,263,589	0.754896	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	570,058	570,058			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,039,277	2,039,277			116.00
200.00		Subtotal (see instructions)	29,028,212	184,751,004	213,779,216			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,028,212	184,751,004	213,779,216			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 2:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINC	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	365,468	7,886,207	0.046343	623,009	28,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82,393	279,085	0.295225	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,292,498	79,084,188	0.016343	597,355	9,763	54.00
60.00	06000	LABORATORY	292,237	41,416,145	0.007056	1,205,702	8,507	60.00
65.00	06500	RESPIRATORY THERAPY	168,716	3,713,893	0.045428	1,102,057	50,064	65.00
66.00	06600	PHYSICAL THERAPY	322,124	4,249,153	0.075809	101,411	7,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,550	1,195,068	0.061545	71,280	4,387	67.00
68.00	06800	SPEECH PATHOLOGY	61,723	610,707	0.101068	32,750	3,310	68.00
69.00	06900	ELECTROCARDIOLOGY	156,552	4,838,823	0.032353	141,533	4,579	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,580	14,116,556	0.005637	1,198,571	6,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	129,680	2,645,821	0.049013	560,621	27,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,386	15,371,564	0.006270	1,801,398	11,295	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	112,745	1,452,922	0.077599	0	0	88.00
90.00	09000	CLINIC	803,666	6,104,664	0.131648	0	0	90.00
90.01	09001	WOUND CLINC	48,752	1,395,185	0.034943	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	95,184	593,697	0.160324	0	0	90.02
91.00	09100	EMERGENCY	604,022	14,396,040	0.041958	22,670	951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	306,034	3,263,589	0.093772	9,067	850	92.00
200.00		Total (lines 50 through 199)	5,091,310	202,613,307		7,467,424	164,500	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,886,207	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	279,085	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,084,188	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,416,145	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,713,893	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,249,153	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,195,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	610,707	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,838,823	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,116,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,645,821	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,371,564	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,452,922	0.000000	88.00
90.00	09000	CLINIC	0	0	0	6,104,664	0.000000	90.00
90.01	09001	WOUND CLINC	0	0	0	1,395,185	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	593,697	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	14,396,040	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,263,589	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	202,613,307		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	623,009	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	597,355	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,205,702	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,102,057	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	101,411	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	71,280	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,750	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	141,533	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,198,571	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	560,621	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,801,398	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0.000000	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	22,670	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	9,067	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,467,424	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.475332	0	1,176,049	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.405199	0	2,978	963	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222958	0	26,618,473	2,930	0	54.00
60.00	06000	LABORATORY	0.176541	0	11,694,363	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.424461	0	431,974	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.487401	0	1,287,436	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541245	0	253,890	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.585826	0	60,173	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.318778	0	1,548,706	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.289197	0	2,519,622	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.731998	0	442,082	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378738	0	3,568,467	677	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.641821	0	1,917,191	0	0	90.00
90.01	09001	WOUND CLINC	0.436757	0	513,008	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.638445	0	29,967	0	0	90.02
91.00	09100	EMERGENCY	0.470495	0	3,740,622	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.754896	0	1,108,236	0	0	92.00
200.00		Subtotal (see instructions)		0	56,913,237	4,570	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	56,913,237	4,570	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	559,014	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,185	1,353	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,934,802	653	54.00
60.00	06000	LABORATORY	2,064,535	0	60.00
65.00	06500	RESPIRATORY THERAPY	183,356	0	65.00
66.00	06600	PHYSICAL THERAPY	627,498	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,417	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,251	0	68.00
69.00	06900	ELECTROCARDIOLOGY	493,693	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	728,667	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	323,603	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,351,514	256	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1,230,493	0	90.00
90.01	09001	WOUND CLINC	224,060	0	90.01
90.02	09002	BEHAVIORAL HEALTH	49,099	0	90.02
91.00	09100	EMERGENCY	1,759,944	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	836,603	0	92.00
200.00		Subtotal (see instructions)	16,543,734	2,262	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	16,543,734	2,262	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,904	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,865	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)	4,228	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	39	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)	1,736	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)	39	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,885,476	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)	58,695	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,826,781	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)	8,826,781	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)	1,504.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,612,663	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)	2,612,663	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	791,029	326	2,426.47	146	354,265	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)	2,719,034	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,685,962	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	58,695	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)	58,695	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)	1,637	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,504.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,463,669	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,103,747	8,885,476	0.124219	2,463,669	306,034	90.00
91.00	Nursing School cost	0	8,885,476	0.000000	2,463,669	0	91.00
92.00	Allied health cost	0	8,885,476	0.000000	2,463,669	0	92.00
93.00	All other Medical Education	0	8,885,476	0.000000	2,463,669	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,904	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,865	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)	4,228	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)	76	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)	842	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,885,476	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)	8,885,476	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)	8,885,476	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)	1,515.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	115,140	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)	115,140	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 2:49 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,388,376	842	1,648.90	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	791,029	326	2,426.47	6	14,559	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)	107,540	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	237,239	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,637	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,515.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,480,055	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 Date/Time Prepared: 7/28/2021 2:49 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,103,747	8,885,476	0.124219	2,480,055	308,070	90.00
91.00	Nursing School cost	0	8,885,476	0.000000	2,480,055	0	91.00
92.00	Allied health cost	0	8,885,476	0.000000	2,480,055	0	92.00
93.00	All other Medical Education	0	8,885,476	0.000000	2,480,055	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,102,250		30.00
31.00	03100	INTENSIVE CARE UNIT		313,420		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475332	623,009	296,136	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.405199	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222958	597,355	133,185	54.00
60.00	06000	LABORATORY	0.176541	1,205,702	212,856	60.00
65.00	06500	RESPIRATORY THERAPY	0.424461	1,102,057	467,780	65.00
66.00	06600	PHYSICAL THERAPY	0.487401	101,411	49,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541245	71,280	38,580	67.00
68.00	06800	SPEECH PATHOLOGY	0.585826	32,750	19,186	68.00
69.00	06900	ELECTROCARDIOLOGY	0.318778	141,533	45,118	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.289197	1,198,571	346,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.731998	560,621	410,373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378738	1,801,398	682,258	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.641821	0	0	90.00
90.01	09001	WOUND CLINC	0.436757	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.638445	0	0	90.02
91.00	09100	EMERGENCY	0.470495	22,670	10,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.754896	9,067	6,845	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,467,424	2,719,034	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)		7,467,424		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3

Component CCN: 15-Z329 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475332	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.405199	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222958	0	0	54.00
60.00	06000	LABORATORY	0.176541	4,062	717	60.00
65.00	06500	RESPIRATORY THERAPY	0.424461	4,305	1,827	65.00
66.00	06600	PHYSICAL THERAPY	0.487401	6,518	3,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541245	9,199	4,979	67.00
68.00	06800	SPEECH PATHOLOGY	0.585826	667	391	68.00
69.00	06900	ELECTROCARDIOLOGY	0.318778	164	52	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.289197	2,396	693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.731998	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378738	15,066	5,706	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.641821	0	0	90.00
90.01	09001	WOUND CLINC	0.436757	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.638445	0	0	90.02
91.00	09100	EMERGENCY	0.470495	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.754896	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		42,377	17,542	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)		42,377		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 2:49 pm
	Title XIX	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		17,621		30.00
31.00	03100	INTENSIVE CARE UNIT		4,461		31.00
43.00	04300	NURSERY		201,504		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475332	11,609	5,518	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.405199	40,834	57,380	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222958	9,493	2,117	54.00
60.00	06000	LABORATORY	0.176541	52,427	9,256	60.00
65.00	06500	RESPIRATORY THERAPY	0.424461	27,953	11,865	65.00
66.00	06600	PHYSICAL THERAPY	0.487401	389	190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541245	274	148	67.00
68.00	06800	SPEECH PATHOLOGY	0.585826	497	291	68.00
69.00	06900	ELECTROCARDIOLOGY	0.318778	3,580	1,141	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.289197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.731998	3,039	2,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378738	35,017	13,262	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.492413	0	0	88.00
90.00	09000	CLINIC	0.641821	0	0	90.00
90.01	09001	WOUND CLINC	0.436757	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.638445	0	0	90.02
91.00	09100	EMERGENCY	0.470495	8,815	4,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.754896	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		193,927	107,540	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)		193,927		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475332	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.405199	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222958	0	0	54.00
60.00	06000	LABORATORY	0.176541	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.424461	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.487401	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.541245	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.585826	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.318778	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.289197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.731998	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378738	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.492413	0	0	88.00
90.00	09000	CLINIC	0.641821	0	0	90.00
90.01	09001	WOUND CLINC	0.436757	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	1.638445	0	0	90.02
91.00	09100	EMERGENCY	0.470495	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.754896	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	16,545,996	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)	16,545,996	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)	16,711,456	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)	125,603	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	9,027,651	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)	7,558,202	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)	7,558,202	30.00
31.00	Primary payer payments	2,773	31.00
32.00	Subtotal (line 30 minus line 31)	7,555,429	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)	487,965	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	317,177	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	487,965	36.00
37.00	Subtotal (see instructions)	7,872,606	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)	7,872,606	40.00
40.01	Sequestration adjustment (see instructions)	51,959	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	8,384,636	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)	-563,989	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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,119,269		8,256,036	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	04/15/2020	128,600	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		128,600	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)		5,119,269		8,384,636	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		28,123		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		563,989	6.02
7.00	Total Medicare program liability (see instructions)		5,147,392		7,820,647	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		18,268		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)		18,268		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		56,999		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		75,267		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/28/2021 2:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	59,282	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	17,717	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	39	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	76,999	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	76,999	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	76,999	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,232	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	75,767	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	75,767	0	19.00
19.01	Sequestration adjustment (see instructions)	500	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	18,268	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	56,999	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1329 Component CCN: 15-Z329	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2 Date/Time Prepared: 7/28/2021 2:49 pm
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,685,962	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,685,962	4.00
5.00	Primary payer payments	10,442	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,732,380	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,732,380	19.00
20.00	Deductibles (exclude professional component)	571,516	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,160,864	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,160,864	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,888	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,727	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	31,888	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,181,591	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	5,181,591	30.00
30.01	Sequestration adjustment (see instructions)	34,199	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	5,119,269	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	28,123	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/28/2021 2:49 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	237,239		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	237,239	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	237,239	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	223,586		8.00
9.00	Ancillary service charges	193,927	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	417,513	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	417,513	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	180,274	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	237,239	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	237,239	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	237,239	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	237,239	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	237,239	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	237,239	0	40.00
41.00	Interim payments	270,123	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-32,884	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/28/2021 2:49 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	6,715,280	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	44,513,017	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,522,510	0	0	0	6.00
7.00	Inventory	1,279,922	0	0	0	7.00
8.00	Prepaid expenses	2,151,883	0	0	0	8.00
9.00	Other current assets	99,430	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)	27,237,022	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,798,684	0	0	0	12.00
13.00	Land improvements	278,583	0	0	0	13.00
14.00	Accumulated depreciation	-217,042	0	0	0	14.00
15.00	Buildings	80,302,549	0	0	0	15.00
16.00	Accumulated depreciation	-48,887,127	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,245,768	0	0	0	19.00
20.00	Accumulated depreciation	-5,173,619	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	62,579,774	0	0	0	23.00
24.00	Accumulated depreciation	-43,730,416	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)	56,197,154	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	103,022,366	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	103,022,366	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	186,456,542	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,187,166	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	8,861,564	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	3,641,633	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	21,690,363	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	33,964,554	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,964,554	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,654,917	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	130,801,625				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)	130,801,625	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	186,456,542	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/28/2021 2:49 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		122,615,112		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,186,513				2.00
3.00	Total (sum of line 1 and line 2)		130,801,625		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)		130,801,625		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)		130,801,625		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: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/28/2021 2:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,246,567		5,246,567	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,246,567		5,246,567	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,004,427		1,004,427	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,004,427		1,004,427	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,250,994		6,250,994	17.00
18.00	Ancillary services	22,129,425	181,336,540	203,465,965	18.00
19.00	Outpatient services	0	47,518	47,518	19.00
20.00	RURAL HEALTH CLINIC	0	1,452,922	1,452,922	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		570,058	570,058	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,039,277	2,039,277	26.00
27.00	OTHER PRO FEES	63,612	17,462,639	17,526,251	27.00
27.01	PRO FEES	2,973,174	19,012,970	21,986,144	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,417,205	221,921,924	253,339,129	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		116,751,679		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)		116,751,679		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/28/2021 2:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	253,339,129	1.00
2.00	Less contractual allowances and discounts on patients' accounts	144,378,029	2.00
3.00	Net patient revenues (line 1 minus line 2)	108,961,100	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	116,751,679	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,790,579	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	702,452	24.00
24.01	CONTRIBUTIONS	230,775	24.01
24.02	INVESTMENT RETURN	32,000	24.02
24.03	UNREALIZED GAIN, DERIVATIVE	7,943,481	24.03
24.04	UNREALIZED GAIN, INVESTMENTS	-240,269	24.04
24.05	TEMPORARILY RESTRICTED ASSETS	0	24.05
24.06	TEMPORARILY RESTRICTED ASSETS	96,800	24.06
24.50	COVID-19 PHE Funding	7,211,853	24.50
25.00	Total other income (sum of lines 6-24)	15,977,092	25.00
26.00	Total (line 5 plus line 25)	8,186,513	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,186,513	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1329 | HHA CCN: 15-7143

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

Worksheet H

Date/Time Prepared: 7/28/2021 2:49 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	178,486	0	0	0	64,427	242,913	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	179,611	0	0	0	0	179,611	6.00
7.00	Physical Therapy	185,157	0	0	0	0	185,157	7.00
8.00	Occupational Therapy	76,223	0	0	0	0	76,223	8.00
9.00	Speech Pathology	1,803	0	0	0	0	1,803	9.00
10.00	Medical Social Services	11,250	0	0	0	0	11,250	10.00
11.00	Home Health Aide	11,356	0	0	0	0	11,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	643,886	0	0	0	64,427	708,313	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	0	242,913	0	242,913	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	179,611	0	179,611	6.00
7.00	Physical Therapy	0	185,157	0	185,157	7.00
8.00	Occupational Therapy	0	76,223	0	76,223	8.00
9.00	Speech Pathology	0	1,803	0	1,803	9.00
10.00	Medical Social Services	0	11,250	0	11,250	10.00
11.00	Home Health Aide	0	11,356	0	11,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	708,313	0	708,313	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-1 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	242,913	0	0	0	0	242,913	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	179,611	0	0	0	0	179,611	6.00
7.00	Physical Therapy	185,157	0	0	0	0	185,157	7.00
8.00	Occupational Therapy	76,223	0	0	0	0	76,223	8.00
9.00	Speech Pathology	1,803	0	0	0	0	1,803	9.00
10.00	Medical Social Services	11,250	0	0	0	0	11,250	10.00
11.00	Home Health Aide	11,356	0	0	0	0	11,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	708,313	0	0	0	0	708,313	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	242,913		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	93,747	273,358	6.00
7.00	Physical Therapy	96,642	281,799	7.00
8.00	Occupational Therapy	39,784	116,007	8.00
9.00	Speech Pathology	941	2,744	9.00
10.00	Medical Social Services	5,872	17,122	10.00
11.00	Home Health Aide	5,927	17,283	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		708,313	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-1 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

HHA CCN: 15-7143

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-242,913	465,400	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	179,611	6.00
7.00	Physical Therapy	0	0	0	0	0	185,157	7.00
8.00	Occupational Therapy	0	0	0	0	0	76,223	8.00
9.00	Speech Pathology	0	0	0	0	0	1,803	9.00
10.00	Medical Social Services	0	0	0	0	0	11,250	10.00
11.00	Home Health Aide	0	0	0	0	0	11,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-242,913	465,400	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		242,913	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.521945	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1329 | HHA CCN: 15-7143

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

Worksheet H-2 Part I

Date/Time Prepared: 7/28/2021 2:49 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	0	47,911	1,586	100,798	1,056	182,394	1.00
2.00	Skilled Nursing Care	273,358	0	0	0	0	0	2.00
3.00	Physical Therapy	281,799	0	0	0	0	0	3.00
4.00	Occupational Therapy	116,007	0	0	0	0	0	4.00
5.00	Speech Pathology	2,744	0	0	0	0	0	5.00
6.00	Medical Social Services	17,122	0	0	0	0	0	6.00
7.00	Home Health Aide	17,283	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	708,313	47,911	1,586	100,798	1,056	182,394	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
1.00	Administrative and General	333,745	70,409	99,973	646	17,795	0	1.00
2.00	Skilled Nursing Care	273,358	57,669	0	0	0	0	2.00
3.00	Physical Therapy	281,799	59,449	0	0	0	0	3.00
4.00	Occupational Therapy	116,007	24,473	0	0	0	0	4.00
5.00	Speech Pathology	2,744	579	0	0	0	0	5.00
6.00	Medical Social Services	17,122	3,612	0	0	0	0	6.00
7.00	Home Health Aide	17,283	3,646	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,042,058	219,837	99,973	646	17,795	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1329 | HHA CCN: 15-7143

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

Worksheet H-2 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	71,069	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	71,069	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	593,637	0	593,637			1.00
2.00	Skilled Nursing Care	0	331,027	0	331,027	229,102	560,129	2.00
3.00	Physical Therapy	0	341,248	0	341,248	236,175	577,423	3.00
4.00	Occupational Therapy	0	140,480	0	140,480	97,225	237,705	4.00
5.00	Speech Pathology	0	3,323	0	3,323	2,300	5,623	5.00
6.00	Medical Social Services	0	20,734	0	20,734	14,350	35,084	6.00
7.00	Home Health Aide	0	20,929	0	20,929	14,485	35,414	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	1,451,378	0	1,451,378	593,637	1,451,378	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.692094		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	2.01	4.00	5A	
1.00	Administrative and General	3,540	149	3,540	149	643,886	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,540	149	3,540	149	643,886		20.00
21.00	Total cost to be allocated	47,911	1,586	100,798	1,056	182,394		21.00
22.00	Unit cost multiplier	13.534181	10.644295	28.474011	7.087248	0.283271		22.00

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	333,745	3,540	149	3,689	0	3,689	1.00
2.00	Skilled Nursing Care	273,358	0	0	0	0	0	2.00
3.00	Physical Therapy	281,799	0	0	0	0	0	3.00
4.00	Occupational Therapy	116,007	0	0	0	0	0	4.00
5.00	Speech Pathology	2,744	0	0	0	0	0	5.00
6.00	Medical Social Services	17,122	0	0	0	0	0	6.00
7.00	Home Health Aide	17,283	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,042,058	3,540	149	3,689	0	3,689	20.00
21.00	Total cost to be allocated	219,837	99,973	646	17,795	0	71,069	21.00
22.00	Unit cost multiplier	0.210964	28.240960	4.335570	4.823800	0.000000	19.265112	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1329 | HHA CCN: 15-7143

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

Worksheet H-3 Part I

Date/Time Prepared: 7/28/2021 2:49 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	560,129		560,129	1,538	364.19	1.00
2.00	Physical Therapy	3.00	577,423	0	577,423	881	655.42	2.00
3.00	Occupational Therapy	4.00	237,705	0	237,705	479	496.25	3.00
4.00	Speech Pathology	5.00	5,623	0	5,623	22	255.59	4.00
5.00	Medical Social Services	6.00	35,084		35,084	0	0.00	5.00
6.00	Home Health Aide	7.00	35,414		35,414	199	177.96	6.00
7.00	Total (sum of lines 1-6)		1,451,378	0	1,451,378	3,119		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	146			8.00
8.01	Skilled Nursing Care		99915	0	905			8.01
9.00	Physical Therapy		17140	0	98			9.00
9.01	Physical Therapy		99915	0	516			9.01
10.00	Occupational Therapy		17140	0	37			10.00
10.01	Occupational Therapy		99915	0	339			10.01
11.00	Speech Pathology		17140	0	4			11.00
11.01	Speech Pathology		99915	0	12			11.01
12.00	Medical Social Services		17140	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		17140	0	25			13.00
13.01	Home Health Aide		99915	0	100			13.01
14.00	Total (sum of lines 8-13)			0	2,182			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,051		0	382,764		1.00
2.00	Physical Therapy	0	614		0	402,428		2.00
3.00	Occupational Therapy	0	376		0	186,590		3.00
4.00	Speech Pathology	0	16		0	4,089		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	125		0	22,245		6.00
7.00	Total (sum of lines 1-6)	0	2,182		0	998,116		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	17,090	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	382,764	1.00
2.00	Physical Therapy	402,428	2.00
3.00	Occupational Therapy	186,590	3.00
4.00	Speech Pathology	4,089	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	22,245	6.00
7.00	Total (sum of lines 1-6)	998,116	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1329
HHA CCN: 15-7143

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

Worksheet H-3
Part II
Date/Time Prepared:
7/28/2021 2:49 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.487401	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.541245	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.585826	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.289197	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.378738	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 7/28/2021 2:49 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	246,873	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	81,491	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	4,782	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	13,989	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	-3,781	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,982	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	345,336	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	345,336	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	345,336	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	345,336	29.00
30.00	OTHER ADJUSTMENTS	0	35,429	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	380,765	31.00
31.01	Sequestration adjustment (see instructions)	0	5,949	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	374,816	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-5 | Date/Time Prepared: 7/28/2021 2:49 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		374,816	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		374,816	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		374,816	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	185,278	100,169	285,447	0	285,447	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	49,386	49,386	0	49,386	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	100,344	100,344	0	100,344	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	11,990	11,990	0	11,990	26.00
27.00	NURSE PRACTITIONER**	3,560	0	3,560	0	3,560	27.00
28.00	REGISTERED NURSE**	382,838	0	382,838	0	382,838	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	62,680	0	62,680	0	62,680	33.00
34.00	SPIRITUAL COUNSELING**	31,926	0	31,926	0	31,926	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	32,599	0	32,599	0	32,599	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	698,881	261,889	960,770	0	960,770	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	285,447	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	49,386	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	100,344	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	11,990	26.00
27.00	NURSE PRACTITIONER**	0	3,560	27.00
28.00	REGISTERED NURSE**	0	382,838	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	62,680	33.00
34.00	SPIRITUAL COUNSELING**	0	31,926	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	32,599	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	960,770	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-2 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	11,990	11,990	0	11,990	26.00
27.00	NURSE PRACTITIONER	3,557	0	3,557	0	3,557	27.00
28.00	REGISTERED NURSE	382,514	0	382,514	0	382,514	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	62,626	0	62,626	0	62,626	33.00
34.00	SPIRITUAL COUNSELING	31,899	0	31,899	0	31,899	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	32,572	0	32,572	0	32,572	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	513,168	11,990	525,158	0	525,158	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	11,990	26.00
27.00	NURSE PRACTITIONER	0	3,557	27.00
28.00	REGISTERED NURSE	0	382,514	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	62,626	33.00
34.00	SPIRITUAL COUNSELING	0	31,899	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	32,572	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	525,158	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-3 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	2	0	2	0	2	27.00
28.00	REGISTERED NURSE	180	0	180	0	180	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	30	0	30	0	30	33.00
34.00	SPIRITUAL COUNSELING	15	0	15	0	15	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	15	0	15	0	15	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	242	0	242	0	242	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	2	27.00
28.00	REGISTERED NURSE	0	180	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	30	33.00
34.00	SPIRITUAL COUNSELING	0	15	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	15	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	242	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-4 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	1	0	1	0	1	27.00
28.00	REGISTERED NURSE	144	0	144	0	144	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	24	0	24	0	24	33.00
34.00	SPIRITUAL COUNSELING	12	0	12	0	12	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	12	0	12	0	12	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	193	0	193	0	193	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	1	27.00
28.00	REGISTERED NURSE	0	144	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	24	33.00
34.00	SPIRITUAL COUNSELING	0	12	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	12	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	193	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-5 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	197,970	197,970	3.00
4.00	ADMINISTRATIVE & GENERAL	285,447	244,452	529,899	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	49,386		49,386	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	100,344	0	100,344	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	525,158		525,158	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	242		242	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	193		193	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	960,770	442,422	1,403,192	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	197,970	0	0	197,970		3.00
4.00	ADMINISTRATIVE & GENERAL	529,899	0	0	0	529,899	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	49,386	0	0	0	49,386	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	100,344	0	0	0	100,344	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	525,158			197,802	722,960	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	242	0	0	93	335	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	193	0	0	75	268	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,403,192	0	0	197,970	1,403,192	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	529,899					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	29,967	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	60,887	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	438,679					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	203	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	163	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	529,899	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			79,353		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	79,286	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	37	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	30	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	79,353	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	161,231					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	161,095	0	0		1,402,020	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	76	0	0	0	651	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	60	0	0	0	521	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	161,231	0	0	0	1,403,192	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	197,973			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-529,899	873,293	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	49,386	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	100,344	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			197,805	0	722,960	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	93	0	335	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	75	0	268	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	197,970		529,899	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.999985		0.606783	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			78,941			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	160,394	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	78,874	0	160,258	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	37	0	76	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	30	0	60	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	79,353	0	161,231	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	1.005219	0.000000	1.005218	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	
		15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL				4.00
5.00	PLANT OPERATION & MAINTENANCE				5.00
6.00	LAUNDRY & LINEN SERVICE				6.00
7.00	HOUSEKEEPING				7.00
8.00	DIETARY				8.00
9.00	NURSING ADMINISTRATION				9.00
10.00	ROUTINE MEDICAL SUPPLIES				10.00
11.00	MEDICAL RECORDS				11.00
12.00	STAFF TRANSPORTATION				12.00
13.00	VOLUNTEER SERVICE COORDINATION				13.00
14.00	PHARMACY				14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			15.00
16.00	OTHER GENERAL SERVICE		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM		0		60.00
61.00	VOLUNTEER PROGRAM		0		61.00
62.00	FUNDRAISING		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		63.00
64.00	PALLIATIVE CARE PROGRAM		0		64.00
65.00	OTHER PHYSICIAN SERVICES		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING		0		67.00
68.00	TELEHEALTH/TELEMONITORING		0		68.00
69.00	THRIFT STORE		0		69.00
70.00	NURSING FACILITY ROOM & BOARD				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER				99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-7 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.487401	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.541245	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.585826	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.378738	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.176541	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.289197	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-8 | Date/Time Prepared: 7/28/2021 2:49 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,402,020	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			10,597	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			132.30	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	8,948	193		9.00
10.00	Program cost (line 8 times line 9)	1,183,820	25,534		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			651	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			5	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			130.20	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	2	0		14.00
15.00	Program cost (line 13 times line 14)	260	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			521	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			4	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			130.25	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	4	0		19.00
20.00	Program cost (line 18 times line 19)	521	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,403,192	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			10,606	22.00
23.00	Average cost per diem (line 21 divided by line 22)			132.30	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1

Component CCN: 15-8511 | Date/Time Prepared: 7/28/2021 2:49 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	37,770	4,000	41,770	0	41,770	1.00
2.00	Physician Assistant	112,912	0	112,912	0	112,912	2.00
3.00	Nurse Practitioner	427,664	0	427,664	0	427,664	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	102,769	0	102,769	0	102,769	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	292,461	0	292,461	0	292,461	9.00
10.00	Subtotal (sum of lines 1 through 9)	973,576	4,000	977,576	0	977,576	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	68,607	68,607	0	68,607	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	68,607	68,607	0	68,607	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	973,576	72,607	1,046,183	0	1,046,183	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	47,873	47,873	0	47,873	29.00
30.00	Administrative Costs	231,959	12,559	244,518	0	244,518	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	231,959	60,432	292,391	0	292,391	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,205,535	133,039	1,338,574	0	1,338,574	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/28/2021 2:49 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	41,770	1.00
2.00	Physician Assistant	0	112,912	2.00
3.00	Nurse Practitioner	0	427,664	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	102,769	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	292,461	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	977,576	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	68,607	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	68,607	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,046,183	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	47,873	29.00
30.00	Administrative Costs	0	244,518	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	292,391	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,338,574	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/28/2021 2:49 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.17	318	1	0		1.00
2.00	Physician Assistant	0.69	1,616	1	1		2.00
3.00	Nurse Practitioner	2.66	6,726	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.52	8,660		4	8,660	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.52	8,660			8,660	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,046,183	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,046,183	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	292,391	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	829,786	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,122,177	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,122,177	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,122,177	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,168,360	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,168,360	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		28,762	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,139,598	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,660	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,660	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		247.07	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	247.07	247.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,623	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	400,995	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	2	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	494	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	494	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	401,489	16.00
16.01	Total program charges (see instructions)(from contractor's records)		249,329	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,579	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		26,697	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		273,603	16.04
16.05	Total program cost (see instructions)	0	300,300	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,788	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,264	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		300,300	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,891	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		313,191	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		313,191	26.00
26.01	Sequestration adjustment (see instructions)		2,067	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		265,315	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		45,809	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/28/2021 2:49 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	977,576	977,576	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000421	0.002162	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	412	2,114	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,030	5,321	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,442	7,435	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,046,183	1,046,183	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,122,177	1,122,177	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006158	0.007107	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,910	7,975	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	13,352	15,410	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	61	313	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	218.89	49.23	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	31	124	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	6,786	6,105	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		28,762	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		12,891	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/28/2021 2:49 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		265,315	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		265,315	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		45,809	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		311,124	7.00

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