

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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S Parts I-III Date/Time Prepared: 3/31/2021 12:34 pm
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 3/31/2021 Time: 12:34 pm

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 DEARBORN COUNTY HOSPITAL (15-0086) for the cost reporting period beginning 01/01/2020 and ending 10/31/2020 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.

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) BILL RITZMANN
Officer or Administrator of Provider(s)

CHIEF OF TRANSITION COMMITTEE
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	127,990	-50,551	0	-114,031	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	127,990	-50,551	0	-114,031	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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/31/2021 12:34 pm
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 600 WILSON CREEK ROAD			PO Box:						1.00	
2.00	City: LAWRENCEBURG			State: IN		Zip Code: 47025-		County: DEARBORN		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	8.00		
		V	XVIII	XIX							
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		DEARBORN COUNTY HOSPITAL	150086	17140	1	07/01/1966	N	P	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										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		HEALTH SERVICES CORP. OF SE IN	157055	17140		10/01/1978	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		HOSPICE OF SOUTHEASTERN INDIANA	151531	17140		12/22/1994				14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FOHC										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		10/31/2020		20.00	
21.00	Type of Control (see instructions)					9				21.00	
						1.00		2.00		3.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/31/2021 12:34 pm	
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		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.	312	941	20	0	420	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	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	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)					Y	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/31/2021 12:34 pm		
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria 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 adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
		Teaching Hospitals that Claim Residents in Nonprovider Settings				
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-2
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	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. 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
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V XIX		
			1.00 2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, 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. 1? 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. 1, 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. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						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
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
						1.00	2.00
						3.00	
				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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.					N	116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.					Y	117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.					1	118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:					421,514	0
						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
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.					Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.					N	122.00
				Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.					N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/31/2021 12:34 pm		
		1.00	2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	Removed and reserved					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:	Contractor's Number:			141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:	Zip Code:			143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00
				1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC	N	N	N	N	161.00
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/31/2021 12:34 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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet S-2 Part II Date/Time Prepared: 3/31/2021 12:34 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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.	Y					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					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.					Y	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/16/2020	Y	12/16/2020		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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/31/2021 12:34 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 relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		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.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JODI		SANDERS	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.	317-713-7956		JSANDERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/31/2021 12:34 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-3
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	54	16,470	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		54	16,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,440	0.00	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)		62	18,910	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	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						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		62				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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-3
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	3,181	309	6,391			1.00
2.00 HMO and other (see instructions)	941	1,361				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,181	309	6,391			7.00
8.00 INTENSIVE CARE UNIT	740	0	1,679			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	500			13.00
14.00 Total (see instructions)	3,921	309	8,570	0.00	470.93	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,673	214	4,866	0.00	12.01	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	27	0	27	0.00	0.26	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	483.20	27.00
28.00 Observation Bed Days		16	1,057			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	23	38			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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-3
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	1,041	78	2,379	1.00
2.00 HMO and other (see instructions)			224	425		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	1,041	78	2,379	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-3
Part II
Date/Time Prepared:
3/31/2021 12:34 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	24,035,545	0	24,035,545	837,558.00	28.70
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,135,277	112,603	1,247,880	38,747.00	32.21
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		373,127	0	373,127	4,359.96	85.58
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		332,500	0	332,500	1,405.00	236.65
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,430,042	0	6,430,042		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		311,895	0	311,895		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-3
Part II
Date/Time Prepared:
3/31/2021 12:34 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	244,817	0	244,817	7,956.00	30.77	26.00
27.00	Administrative & General	3,743,289	0	3,743,289	127,839.00	29.28	27.00
28.00	Administrative & General under contract (see inst.)	574,929	0	574,929	4,394.00	130.84	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	670,382	-46,702	623,680	22,241.00	28.04	30.00
31.00	Laundry & Linen Service	69,901	0	69,901	5,037.00	13.88	31.00
32.00	Housekeeping	663,160	0	663,160	46,604.00	14.23	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	596,705	-378,490	218,215	13,259.00	16.46	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	378,490	378,490	22,997.00	16.46	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	969,807	0	969,807	26,443.00	36.68	38.00
39.00	Central Services and Supply	219,567	0	219,567	11,734.00	18.71	39.00
40.00	Pharmacy	1,060,908	-65,901	995,007	23,265.00	42.77	40.00
41.00	Medical Records & Medical Records Library	471,302	0	471,302	20,542.00	22.94	41.00
42.00	Social Service	184,698	0	184,698	6,062.00	30.47	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet S-3
Part III
Date/Time Prepared:
3/31/2021 12:34 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	24,610,474	0	24,610,474	841,952.00	29.23	1.00
2.00	Excluded area salaries (see instructions)	1,135,277	112,603	1,247,880	38,747.00	32.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,475,197	-112,603	23,362,594	803,205.00	29.09	3.00
4.00	Subtotal other wages & related costs (see inst.)	705,627	0	705,627	5,764.96	122.40	4.00
5.00	Subtotal wage-related costs (see inst.)	6,430,042	0	6,430,042	0.00	27.52	5.00
6.00	Total (sum of lines 3 thru 5)	30,610,866	-112,603	30,498,263	808,969.96	37.70	6.00
7.00	Total overhead cost (see instructions)	9,469,465	-112,603	9,356,862	338,373.00	27.65	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 3/31/2021 12:34 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	396,915	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,618,388	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	106,659	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,782	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	73,042	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	265,277	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,433,072	17.00
18.00	Medicare Taxes - Employers Portion Only	341,421	18.00
19.00	Unemployment Insurance	305,154	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	163,228	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,741,938	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-3 Part V Date/Time Prepared: 3/31/2021 12:34 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	373,127	6,741,938	1.00
2.00	Hospital	373,127	6,741,938	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0086 Component CCN: 15-7055		Period: From 01/01/2020 To 10/31/2020		Worksheet S-4 Date/Time Prepared: 3/31/2021 12:34 pm	
				Home Health Agency I		PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	865	58	388	1,311	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	218.00	0.00	0.00	218.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		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)			0.64	0.00	0.64	4.00
5.00	Other Administrative Personnel			2.02	0.00	2.02	5.00
6.00	Direct Nursing Service			4.66	0.00	4.66	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.19	0.00	2.19	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.26	0.00	0.26	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			0.02	0.00	0.02	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.63	0.00	0.63	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		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,180	121	47	28	1,376	21.00
22.00	Skilled Nursing Visit Charges	236,865	24,285	9,433	5,620	276,203	22.00
23.00	Physical Therapy Visits	875	38	11	17	941	23.00
24.00	Physical Therapy Visit Charges	192,603	8,370	2,423	3,744	207,140	24.00
25.00	Occupational Therapy Visits	180	27	0	6	213	25.00
26.00	Occupational Therapy Visit Charges	39,645	5,947	0	1,322	46,914	26.00
27.00	Speech Pathology Visits	2	14	0	0	16	27.00
28.00	Speech Pathology Visit Charges	441	3,084	0	0	3,525	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	104	9	0	14	127	31.00
32.00	Home Health Aide Visit Charges	23,383	1,752	0	3,270	28,405	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,341	209	58	65	2,673	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)	492,937	43,438	11,856	13,956	562,187	35.00
36.00	Total Number of Episodes (standard/non outlier)	253		34	7	294	36.00
37.00	Total Number of Outlier Episodes		9		0	9	37.00
38.00	Total Non-Routine Medical Supply Charges	10,139	3,943	318	0	14,400	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0086 Hospice CCN: 15-1531	Period: From 01/01/2020 To 10/31/2020	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 3/31/2021 12:34 pm
			Hospice I	

	Unduplicated Days	Hospice I					Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1.00	2.00	3.00	4.00	5.00		
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	41	0	0	41	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	7	0	0	7	13.00
14.00	Total Hospice Days	48	0	0	48	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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet S-10 Date/Time Prepared: 3/31/2021 12:34 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)			0.293973	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,509,374	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			18,562,628	6.00
7.00	Medicaid cost (line 1 times line 6)			5,456,911	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)			2,947,537	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)			2,947,537	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)	251,586	91,921	343,507	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	73,959	91,921	165,880	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)	73,959	91,921	165,880	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)			541,071	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			85,613	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			131,711	27.01
28.00	Non-Medicare bad debt expense (see instructions)			409,360	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			166,439	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			332,319	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,279,856	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet A Date/Time Prepared: 3/31/2021 12:34 pm
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ions (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		2,278,407	964,932	3,243,339
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,265,660	0	1,265,660
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	244,817	6,750,991	0	6,995,808
5.01	01160	COMMUNICATIONS	87,794	82,863	170,657	170,657
5.02	00550	DATA PROCESSING	735,012	2,168,560	0	2,903,572
5.03	00560	PURCHASING RECEIVING AND STORES	139,028	15,042	154,070	154,357
5.04	00570	ADMINISTRATION	641,282	51,611	692,893	692,893
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	285,243	1,197,441	0	1,482,684
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	1,854,930	7,164,620	-205,854	8,813,696
7.00	00700	OPERATION OF PLANT	670,382	1,511,803	-49,459	2,132,726
8.00	00800	LAUNDRY & LINEN SERVICE	69,901	246,106	0	316,007
9.00	00900	HOUSEKEEPING	663,160	185,904	20,835	869,899
10.00	01000	DIETARY	596,705	327,494	-586,220	337,979
11.00	01100	CAFETERIA	0	0	586,220	586,220
13.00	01300	NURSING ADMINISTRATION	969,807	328,884	0	1,298,691
14.00	01400	CENTRAL SERVICE & SUPPLY	219,567	240,593	-115,188	344,972
15.00	01500	PHARMACY	1,060,908	290,490	-120,278	1,231,120
16.00	01600	MEDICAL RECORDS & LIBRARY	471,302	115,187	-6,241	580,248
17.00	01700	SOCIAL SERVICE	184,698	2,645	0	187,343
23.00	02300	PHARMACY RESIDENCY	67,270	6,147	65,901	139,318
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,086,674	776,845	-689,686	4,173,833
31.00	03100	INTENSIVE CARE UNIT	1,146,640	169,408	-59	1,315,989
43.00	04300	NURSERY	0	0	428,372	428,372
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,206,241	2,407,281	-1,141,293	2,472,229
51.00	05100	RECOVERY ROOM	494,769	95,485	-1,530	588,724
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	252,739	252,739
53.00	05300	ANESTHESIOLOGY	0	1,878,183	-214,816	1,663,367
54.00	05400	RADIOLOGY-DIAGNOSTIC	823,967	476,350	-3,079	1,297,238
54.01	05401	ULTRASOUND	149,528	53,876	-17,370	186,034
55.00	05500	RADIOLOGY-THERAPEUTIC	279,740	152,876	-34,622	397,994
57.00	05700	CT SCAN	398,133	297,872	-47,523	648,482
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,853	255,414	-9,892	431,375
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	1,623,653	2,644,501	-279	4,267,875
60.01	06001	BLOOD LABORATORY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	566,496	125,082	-23,378	668,200
65.01	03950	SLEEP CLINIC	0	178,756	0	178,756
66.00	06600	PHYSICAL THERAPY	849,525	51,870	-90	901,305
67.00	06700	OCCUPATIONAL THERAPY	169,698	12,060	-1,770	179,988
68.00	06800	SPEECH PATHOLOGY	155,138	1,645	0	156,783
69.00	06900	ELECTROCARDIOLOGY	493,008	241,993	0	735,001
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,677,205	1,677,205
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,132,331	0	3,132,331
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,248,258	0	2,248,258
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,376,669	311,819	-1,369	1,687,119
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	675,891	137,179	-704	812,366
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		829,153	-769,974	59,179
116.00	11600	HOSPICE	13,018	38,381	-1,574	49,825
118.00	11800	SUBTOTALS (SUM OF LINES 1 through 117)	23,656,447	40,747,066	-45,757	64,357,756
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,778	203,682	45,761	260,221
192.01	19201	PHYSICIAN CLINIC	7,776	27,356	0	35,132
192.02	19202	LIFELINE	0	1,138	0	1,138
192.03	19203	CREDIT UNION	0	0	0	0
192.04	19204	ENT	0	254,405	0	254,405
192.05	19205	HOSPITALIST	0	1,306,580	0	1,306,580
192.06	19206	ORTHO	0	815,680	0	815,680
192.07	19207	ATHLETIC TRAINERS	43,819	3,748	0	47,567
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	0	0
194.01	07951	MARKETING	107,982	87,924	0	195,906
194.02	07953	OCCUPATIONAL HEALTH	139,259	40,378	-4	179,633
194.03	07952	PATHS EDUCATION	0	2,992	0	2,992

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020	Worksheet A Date/Time Prepared: 3/31/2021 12:34 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
194.04	07954 FOUNDATION	69,484	5,445	74,929	0	74,929
200.00	TOTAL (SUM OF LINES 118 through 199)	24,035,545	43,496,394	67,531,939	0	67,531,939
						194.04 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A
Date/Time Prepared:
3/31/2021 12:34 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	-144,826	3,098,513	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-6,698	1,258,962	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,669	6,993,139	4.00
5.01	01160	COMMUNICATIONS	-4,948	165,709	5.01
5.02	00550	DATA PROCESSING	0	2,903,572	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	154,357	5.03
5.04	00570	ADMITTING	0	692,893	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-2,397	1,480,287	5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	-5,076,875	3,736,821	5.06
7.00	00700	OPERATION OF PLANT	-101,877	2,030,849	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	316,007	8.00
9.00	00900	HOUSEKEEPING	0	869,899	9.00
10.00	01000	DIETARY	-2,288	335,691	10.00
11.00	01100	CAFETERIA	-215,664	370,556	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,298,691	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	344,972	14.00
15.00	01500	PHARMACY	0	1,231,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,309	565,939	16.00
17.00	01700	SOCIAL SERVICE	0	187,343	17.00
23.00	02300	PHARMACY RESIDENCY	0	139,318	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-225,527	3,948,306	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,315,989	31.00
43.00	04300	NURSERY	0	428,372	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-50,500	2,421,729	50.00
51.00	05100	RECOVERY ROOM	0	588,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	252,739	52.00
53.00	05300	ANESTHESIOLOGY	-1,575,000	88,367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,628	1,287,610	54.00
54.01	05401	ULTRASOUND	0	186,034	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	397,994	55.00
57.00	05700	CT SCAN	-1,100	647,382	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	431,375	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-133,622	4,134,253	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-6,478	661,722	65.00
65.01	03950	SLEEP CLINIC	0	178,756	65.01
66.00	06600	PHYSICAL THERAPY	0	901,305	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	179,988	67.00
68.00	06800	SPEECH PATHOLOGY	0	156,783	68.00
69.00	06900	ELECTROCARDIOLOGY	-157,134	577,867	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,677,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,132,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-691,445	1,556,813	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-83,087	1,604,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	812,366	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-59,179	0	113.00
116.00	11600	HOSPICE	-280	49,545	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,565,531	55,792,225	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	260,221	192.00
192.01	19201	PHYSICIAN CLINIC	0	35,132	192.01
192.02	19202	LIFELINE	0	1,138	192.02
192.03	19203	CREDIT UNION	0	0	192.03
192.04	19204	ENT	0	254,405	192.04
192.05	19205	HOSPITALIST	0	1,306,580	192.05
192.06	19206	ORTHO	0	815,680	192.06
192.07	19207	ATHLETIC TRAINERS	0	47,567	192.07
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	194.00
194.01	07951	MARKETING	0	195,906	194.01
194.02	07953	OCCUPATIONAL HEALTH	0	179,633	194.02
194.03	07952	PATHS EDUCATION	0	2,992	194.03
194.04	07954	FOUNDATION	0	74,929	194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020	Worksheet A Date/Time Prepared: 3/31/2021 12:34 pm
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	-8,565,531	58,966,408	200.00	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	378,490	207,730	1.00
	O		378,490	207,730	
B - NURSERY					
1.00	NURSERY	43.00	351,248	77,124	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	207,236	45,503	2.00
	O		558,484	122,627	
C - UTILIZATION REVIEW COST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	6,241	1.00
	O		0	6,241	
D - SECURITY GUARD					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	46,702	143	1.00
	O		46,702	143	
E - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,677,205	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	287	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
	O		0	1,677,492	
F - POB HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	20,835	1.00
2.00		0.00	0	0	2.00
	O		0	20,835	
G - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	194,958	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17,137	2.00
	O		0	212,095	
H - PHARMACY RESIDENCY RECLASS					
1.00	PHARMACY RESIDENCY	23.00	65,901	0	1.00
	TOTALS		65,901	0	
I - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	769,974	1.00
	O		0	769,974	
500.00	Grand Total: Increases		1,049,577	3,017,137	500.00

RECLASSIFICATIONS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A-6

Date/Time Prepared:
3/31/2021 12:34 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	378,490	207,730	0		1.00
	O		378,490	207,730			
B - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	558,484	122,627	0		1.00
2.00		0.00	0	0	0		2.00
	O		558,484	122,627			
C - UTILIZATION REVIEW COST							
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,241	0		1.00
	O		0	6,241			
D - SECURITY GUARD							
1.00	OPERATION OF PLANT	7.00	46,702	143	0		1.00
	O		46,702	143			
E - MED SUPPLY RECLASS							
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	115,188	0		1.00
2.00	PHARMACY	15.00	0	54,377	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	8,575	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	59	0		4.00
5.00	OPERATING ROOM	50.00	0	1,141,293	0		5.00
6.00	RECOVERY ROOM	51.00	0	1,530	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	214,816	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,079	0		8.00
9.00	ULTRASOUND	54.01	0	17,370	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	34,622	0		10.00
11.00	CT SCAN	57.00	0	47,523	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	9,892	0		12.00
13.00	LABORATORY	60.00	0	279	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	23,378	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	90	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	1,770	0		16.00
17.00	EMERGENCY	91.00	0	1,369	0		17.00
18.00	HOME HEALTH AGENCY	101.00	0	704	0		18.00
19.00	HOSPICE	116.00	0	1,574	0		19.00
20.00	OCCUPATIONAL HEALTH	194.02	0	4	0		20.00
	O		0	1,677,492			
F - POB HOUSEKEEPING							
1.00	OPERATION OF PLANT	7.00	0	2,614	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	18,221	0		2.00
	O		0	20,835			
G - INSURANCE							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	212,095	12		1.00
2.00		0.00	0	0	0		2.00
	O		0	212,095			
H - PHARMACY RESIDENCY RECLASS							
1.00	PHARMACY	15.00	65,901	0	0		1.00
	TOTALS		65,901	0			
I - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	769,974	11		1.00
	O		0	769,974			
500.00	Grand Total: Decreases		1,049,577	3,017,137			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A-7
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,408,112	0	0	0	1,332,904	1.00
2.00	Land Improvements	2,615,940	0	0	0	1,066,970	2.00
3.00	Buildings and Fixtures	75,035,220	0	0	0	5,615,193	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	68,056,494	0	0	0	10,962,726	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147,115,766	0	0	0	18,977,793	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	147,115,766	0	0	0	18,977,793	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	75,208	0				1.00
2.00	Land Improvements	1,548,970	0				2.00
3.00	Buildings and Fixtures	69,420,027	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	57,093,768	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	128,137,973	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	128,137,973	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A-7
Part II
Date/Time Prepared:
3/31/2021 12:34 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	2,278,407	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,265,660	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,544,067	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,278,407				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,265,660				2.00
3.00	Total (sum of lines 1-2)	0	3,544,067				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A-7
Part III
Date/Time Prepared:
3/31/2021 12:34 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	128,137,973	0	128,137,973	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	128,137,973	0	128,137,973	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	2,133,581	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,258,962	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,392,543	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	769,974	194,958	0	0	3,098,513	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,258,962	2.00
3.00	Total (sum of lines 1-2)	769,974	194,958	0	0	4,357,475	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A-8

Date/Time Prepared:
3/31/2021 12:34 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.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-5,667	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-4,948	COMMUNICATIONS	5.01	0	7.00
8.00 Television and radio service (chapter 21)	A	-6,698	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,229,806			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	-215,664	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-691,445	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-14,309	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			*** 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		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 REV - FITNESS CENTER	B	-2,669		EMPLOYEE BENEFITS DEPARTMENT	4.00	33.00
35.00 SISIC BILLING SERVICES	B	-2,397		CASHIERING/ACCOUNTS RECEIVABLE	5.05	35.00
36.00 HEALTH SERV/WIC MANAGMNT FEE	B	-4,324		OTHER ADMINISTRATIVE AND GENERAL	5.06	36.00
37.00 RENT - LUDLOW HILL CLINIC	B	-19,692		OTHER ADMINISTRATIVE AND GENERAL	5.06	37.00
39.00 DIET - NUTRITION COUNSELING	B	-2,288		DIETARY	10.00	39.00
40.00 REV - COMMUNITY EDUCATION PROGRAM	B	-2,642		ADULTS & PEDIATRICS	30.00	40.00
40.01 MISCELLANEOUS INCOME	B	-9,628		RADIOLOGY-DIAGNOSTIC	54.00	40.01
42.00 ADVERTISING	A	100		OTHER ADMINISTRATIVE AND GENERAL	5.06	42.00
43.00 AHA & IHA DUES	A	-7,442		OTHER ADMINISTRATIVE AND GENERAL	5.06	43.00
44.00 MISC. OFFSET	A	-1,502,387		OTHER ADMINISTRATIVE AND GENERAL	5.06	44.00
45.00 MISC. NONALLOWABLE	A	-280		HOSPICE	116.00	45.00
45.01 ADVERTISING STAFF	A	-1,085		OTHER ADMINISTRATIVE AND GENERAL	5.06	45.01
45.02 NON ALLOWABLE REPAIRS	A	-71,494		OPERATION OF PLANT	7.00	45.02
45.03 PHYSICIAN RECRUITMENT & HSC LOSS	A	-117,818		OTHER ADMINISTRATIVE AND GENERAL	5.06	45.03
45.04 MENTAL HEALTH UTILITIES	A	-30,383		OPERATION OF PLANT	7.00	45.04
45.05 NON-ALLOWABLE DEPRECIATION	A	-144,826		NEW CAP REL COSTS-BLDG & FIXT	1.00	45.05
45.06 NON ALLOWABLE INTEREST	A	-59,179		INTEREST EXPENSE	113.00	45.06
45.07 HAF OFFSET	A	-3,418,560		OTHER ADMINISTRATIVE AND GENERAL	5.06	45.07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,565,531				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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet A-8-2

Date/Time Prepared:
3/31/2021 12:34 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	30.00	ADULTS & PEDIATRICS	222,885	222,885	0	0	0	1.00
2.00	50.00	OPERATING ROOM	50,500	50,500	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	1,575,000	1,575,000	0	0	0	3.00
4.00	57.00	CT SCAN	1,100	1,100	0	0	0	4.00
5.00	60.00	LABORATORY	208,333	0	208,333	260,300	597	5.00
6.00	65.00	RESPIRATORY THERAPY	12,840	2,840	10,000	197,500	67	6.00
7.00	69.00	ELECTROCARDIOLOGY	157,134	157,134	0	0	0	7.00
8.00	91.00	EMERGENCY	146,856	32,689	114,167	179,000	741	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,374,648	2,042,148	332,500		1,405	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	57.00	CT SCAN	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	74,711	3,736	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	6,362	318	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	63,769	3,188	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			144,842	7,242	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	222,885	1.00
2.00	50.00	OPERATING ROOM	0	0	0	50,500	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	1,575,000	3.00
4.00	57.00	CT SCAN	0	0	0	1,100	4.00
5.00	60.00	LABORATORY	0	74,711	133,622	133,622	5.00
6.00	65.00	RESPIRATORY THERAPY	0	6,362	3,638	6,478	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	157,134	7.00
8.00	91.00	EMERGENCY	0	63,769	50,398	83,087	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	144,842	187,658	2,229,806	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	3,098,513	3,098,513				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	1,258,962		1,258,962			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	6,993,139	21,658	8,800	7,023,597		4.00
5.01 01160 COMMUNICATIONS	165,709	3,088	1,255	25,919	195,971	5.01
5.02 00550 DATA PROCESSING	2,903,572	35,839	14,562	216,993	11,575	5.02
5.03 00560 PURCHASING RECEIVING AND STORES	154,357	64,922	26,379	41,044	2,251	5.03
5.04 00570 ADMITTING	692,893	35,097	14,260	189,322	4,501	5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	1,480,287	21,465	8,721	84,211	8,038	5.05
5.06 00591 OTHER ADMINISTRATIVE AND GENERAL	3,736,821	132,434	53,810	547,620	6,913	5.06
7.00 00700 OPERATION OF PLANT	2,030,849	991,360	402,802	184,125	6,752	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	316,007	16,172	6,571	20,636	482	8.00
9.00 00900 HOUSEKEEPING	869,899	11,967	4,862	195,781	2,894	9.00
10.00 01000 DIETARY	335,691	40,633	16,510	64,422	804	10.00
11.00 01100 CAFETERIA	370,556	28,819	11,710	111,739	2,733	11.00
13.00 01300 NURSING ADMINISTRATION	1,298,691	6,095	2,476	286,310	2,572	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	344,972	72,002	29,255	64,821	3,055	14.00
15.00 01500 PHARMACY	1,231,120	15,065	6,121	293,750	4,662	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	565,939	48,831	19,841	139,140	11,736	16.00
17.00 01700 SOCIAL SERVICE	187,343	2,286	929	54,527	2,251	17.00
23.00 02300 PHARMACY RESIDENCY	139,318	2,976	1,209	39,315	1,125	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,948,306	653,333	265,457	1,041,613	23,150	30.00
31.00 03100 INTENSIVE CARE UNIT	1,315,989	75,172	30,543	338,516	2,733	31.00
43.00 04300 NURSERY	428,372	4,063	1,651	103,697	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2,421,729	261,943	106,430	356,111	9,003	50.00
51.00 05100 RECOVERY ROOM	588,724	11,814	4,800	146,068	2,572	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	252,739	5,120	2,080	61,181	0	52.00
53.00 05300 ANESTHESIOLOGY	88,367	163	66	0	1,125	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,287,610	119,127	48,403	243,255	10,932	54.00
54.01 05401 ULTRASOUND	186,034	6,298	2,559	44,144	322	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	397,994	11,733	4,767	82,586	965	55.00
57.00 05700 CT SCAN	647,382	0	0	117,538	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	431,375	8,157	3,314	54,868	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	4,134,253	68,264	27,736	479,341	6,270	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	661,722	11,824	4,804	167,243	1,125	65.00
65.01 03950 SLEEP CLINIC	178,756	0	0	0	804	65.01
66.00 06600 PHYSICAL THERAPY	901,305	76,838	31,220	250,800	2,894	66.00
67.00 06700 OCCUPATIONAL THERAPY	179,988	8,066	3,277	50,099	1,768	67.00
68.00 06800 SPEECH PATHOLOGY	156,783	4,307	1,750	45,800	161	68.00
69.00 06900 ELECTROCARDIOLOGY	577,867	33,126	13,460	145,548	5,948	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,677,205	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3,132,331	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,556,813	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	1,604,032	98,373	39,970	406,426	5,305	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	812,366	15,085	6,129	199,539	965	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	49,545	3,200	1,300	3,843	0	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1 through 117)	55,792,225	3,026,715	1,229,789	6,897,891	148,386	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,786	10,071	0	804	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	260,221	0	0	16,969	42,119	192.00
192.01 19201 PHYSICIAN CLINIC	35,132	17,269	7,017	2,296	1,447	192.01
192.02 19202 LIFELINE	1,138	0	0	0	0	192.02
192.03 19203 CREDIT UNION	0	10,626	4,317	0	1,768	192.03
192.04 19204 ENT	254,405	0	0	0	0	192.04
192.05 19205 HOSPITALIST	1,306,580	3,982	1,618	0	0	192.05
192.06 19206 ORTHO	815,680	0	0	0	0	192.06
192.07 19207 ATHLETIC TRAINERS	47,567	0	0	12,936	0	192.07
194.00 07950 COMMUNITY MENTAL HEALTH	0	0	0	0	0	194.00
194.01 07951 MARKETING	195,906	9,396	3,818	31,879	482	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
194.02 07953 OCCUPATIONAL HEALTH	179,633	0	0	41,113	643	194.02
194.03 07952 PATHS EDUCATION	2,992	0	0	0	0	194.03
194.04 07954 FOUNDATION	74,929	5,739	2,332	20,513	322	194.04
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)	58,966,408	3,098,513	1,258,962	7,023,597	195,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550	3,182,541					5.02
5.03	00560	38,076	327,029				5.03
5.04	00570	104,710	706	1,041,489			5.04
5.05	00580	164,997	135	0	1,767,854		5.05
5.06	00591	171,343	8,097	0	0	4,657,038	5.06
7.00	00700	44,422	2,108	0	0	3,662,418	7.00
8.00	00800	0	9,051	0	0	368,919	8.00
9.00	00900	15,865	2,660	0	0	1,103,928	9.00
10.00	01000	101,537	814	0	0	560,411	10.00
11.00	01100	0	0	0	0	525,557	11.00
13.00	01300	53,941	10,404	0	0	1,660,489	13.00
14.00	01400	66,633	6,476	0	0	587,214	14.00
15.00	01500	88,845	3,337	0	0	1,642,900	15.00
16.00	01600	171,343	458	0	0	957,288	16.00
17.00	01700	28,557	89	0	0	275,982	17.00
23.00	02300	9,519	365	0	0	193,827	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	564,800	13,046	766,099	111,457	7,387,261	30.00
31.00	03100	85,672	4,541	160,319	49,384	2,062,869	31.00
43.00	04300	0	0	115,071	4,088	656,942	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	199,900	69,967	0	407,710	3,832,793	50.00
51.00	05100	0	2,284	0	26,584	782,846	51.00
52.00	05200	0	0	0	12,782	333,902	52.00
53.00	05300	0	11,046	0	40,273	141,040	53.00
54.00	05400	152,305	5,055	0	92,373	1,959,060	54.00
54.01	05401	0	781	0	19,300	259,438	54.01
55.00	05500	31,730	2,604	0	26,163	558,542	55.00
57.00	05700	0	3,806	0	155,893	924,619	57.00
58.00	05800	0	1,063	0	23,459	522,236	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	215,765	41,828	0	253,377	5,226,834	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	114,229	2,256	0	26,518	989,721	65.00
65.01	03950	0	248	0	4,262	184,070	65.01
66.00	06600	69,806	469	0	25,089	1,358,421	66.00
67.00	06700	0	162	0	7,628	250,988	67.00
68.00	06800	0	52	0	4,101	212,954	68.00
69.00	06900	0	508	0	50,308	826,765	69.00
71.00	07100	0	0	0	53,323	1,730,528	71.00
72.00	07200	0	116,010	0	89,362	3,337,703	72.00
73.00	07300	0	0	0	78,371	1,635,184	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	107,883	5,307	0	196,882	2,464,178	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	130,094	611	0	8,870	1,173,659	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	73	0	297	58,258	116.00
118.00	11800	2,731,972	326,417	1,041,489	1,767,854	55,066,782	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	35,661	190.00
192.00	19200	406,147	453	0	0	725,909	192.00
192.01	19201	28,557	29	0	0	91,747	192.01
192.02	19202	0	0	0	0	1,138	192.02
192.03	19203	0	0	0	0	16,711	192.03
192.04	19204	0	0	0	0	254,405	192.04
192.05	19205	12,692	22	0	0	1,324,894	192.05
192.06	19206	0	0	0	0	815,680	192.06
192.07	19207	0	0	0	0	60,503	192.07
194.00	07950	0	0	0	0	0	194.00
194.01	07951	3,173	51	0	0	244,705	194.01
194.02	07953	0	57	0	0	221,446	194.02
194.03	07952	0	0	0	0	2,992	194.03
194.04	07954	0	0	0	0	103,835	194.04
200.00						0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
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Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,182,541	327,029	1,041,489	1,767,854	58,966,408	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591	4,657,038					5.06
7.00	00700	314,052	3,976,470				7.00
8.00	00800	31,635	35,873	436,427			8.00
9.00	00900	94,662	26,544	0	1,225,134		9.00
10.00	01000	48,055	90,133	4,389	28,212	731,200	10.00
11.00	01100	45,067	63,927	7,613	20,010	0	11.00
13.00	01300	142,387	13,520	0	4,232	0	13.00
14.00	01400	50,354	159,716	5,937	49,993	0	14.00
15.00	01500	140,879	33,417	0	10,460	0	15.00
16.00	01600	82,087	108,317	0	33,904	0	16.00
17.00	01700	23,665	5,070	0	1,587	0	17.00
23.00	02300	16,621	6,602	0	2,067	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	633,465	1,449,228	172,164	453,619	494,683	30.00
31.00	03100	176,891	166,746	31,196	52,193	54,027	31.00
43.00	04300	56,333	9,013	0	2,821	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	328,662	581,043	52,574	181,872	0	50.00
51.00	05100	67,129	26,206	0	8,203	795	51.00
52.00	05200	28,632	11,357	0	3,555	0	52.00
53.00	05300	12,094	361	0	113	0	53.00
54.00	05400	167,989	264,248	27,913	82,712	0	54.00
54.01	05401	22,247	13,971	9,563	4,373	0	54.01
55.00	05500	47,895	26,026	2,269	8,146	0	55.00
57.00	05700	79,286	0	0	0	0	57.00
58.00	05800	44,782	18,094	0	5,664	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	448,201	151,424	96	47,397	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	84,869	26,229	7,992	8,210	0	65.00
65.01	03950	15,784	0	0	0	0	65.01
66.00	06600	116,485	170,442	7,472	53,350	0	66.00
67.00	06700	21,522	17,891	1,070	5,600	0	67.00
68.00	06800	18,261	9,554	0	2,991	0	68.00
69.00	06900	70,895	73,481	2,041	23,000	0	69.00
71.00	07100	148,393	0	0	0	0	71.00
72.00	07200	286,208	0	0	0	0	72.00
73.00	07300	140,217	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	211,303	218,212	98,620	68,302	14,152	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	100,641	33,462	0	10,474	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	4,996	7,098	0	2,222	0	116.00
118.00		4,322,644	3,817,205	430,909	1,175,282	563,657	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	3,058	54,981	0	17,210	0	190.00
192.00	19200	62,247	0	0	0	0	192.00
192.01	19201	7,867	38,307	0	11,990	0	192.01
192.02	19202	98	0	0	0	0	192.02
192.03	19203	1,433	23,570	0	7,378	0	192.03
192.04	19204	21,815	0	0	0	0	192.04
192.05	19205	113,610	8,833	0	2,765	0	192.05
192.06	19206	69,945	0	0	0	0	192.06
192.07	19207	5,188	0	0	0	0	192.07
194.00	07950	0	0	5,518	0	167,543	194.00
194.01	07951	20,983	20,843	0	6,524	0	194.01
194.02	07953	18,989	0	0	0	0	194.02
194.03	07952	257	0	0	0	0	194.03
194.04	07954	8,904	12,731	0	3,985	0	194.04
200.00							200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0086			Period: From 01/01/2020 To 10/31/2020		Worksheet B Part I Date/Time Prepared: 3/31/2021 12:34 pm	
Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,657,038	3,976,470	436,427	1,225,134	731,200		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	662,174					11.00
13.00	01300	31,646	1,852,274				13.00
14.00	01400	14,043	75,027	942,284			14.00
15.00	01500	27,842	0	0	1,855,498		15.00
16.00	01600	24,584	0	0	0	1,206,180	16.00
17.00	01700	7,255	0	0	0	0	17.00
23.00	02300	4,325	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	152,022	812,225	0	0	76,044	30.00
31.00	03100	43,642	233,169	0	0	33,694	31.00
43.00	04300	12,656	67,616	0	0	2,789	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	41,790	223,277	0	0	278,184	50.00
51.00	05100	17,810	95,155	0	0	18,138	51.00
52.00	05200	7,466	39,892	0	0	8,721	52.00
53.00	05300	0	0	0	0	27,477	53.00
54.00	05400	34,098	0	0	0	63,024	54.00
54.01	05401	4,848	0	0	0	13,168	54.01
55.00	05500	8,833	0	0	0	17,850	55.00
57.00	05700	0	0	0	0	106,363	57.00
58.00	05800	0	0	0	0	16,005	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	78,080	0	0	0	172,874	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	21,236	0	0	0	18,092	65.00
65.01	03950	0	0	0	0	2,908	65.01
66.00	06600	29,798	0	0	0	17,118	66.00
67.00	06700	5,042	0	0	0	5,204	67.00
68.00	06800	4,124	0	0	0	2,798	68.00
69.00	06900	17,190	0	0	0	34,324	69.00
71.00	07100	0	0	942,284	0	36,381	71.00
72.00	07200	0	0	0	0	60,970	72.00
73.00	07300	0	0	0	1,855,498	53,471	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	57,257	305,913	0	0	134,329	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	6,052	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	202	116.00
118.00		645,587	1,852,274	942,284	1,855,498	1,206,180	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	2,373	0	0	0	0	192.00
192.01	19201	639	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
192.07	19207	2,006	0	0	0	0	192.07
194.00	07950	0	0	0	0	0	194.00
194.01	07951	3,874	0	0	0	0	194.01
194.02	07953	5,178	0	0	0	0	194.02
194.03	07952	0	0	0	0	0	194.03
194.04	07954	2,517	0	0	0	0	194.04
200.00							200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
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To 10/31/2020

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	662,174	1,852,274	942,284	1,855,498	1,206,180	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet B Part I Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description		SOCIAL SERVICE	PHARMACY RESIDENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	313,559				17.00
23.00	02300	PHARMACY RESIDENCY	0	223,442			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	270,186	0	11,900,897	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,153	0	2,866,580	0	31.00
43.00	04300	NURSERY	0	0	808,170	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,829	0	5,534,024	0	50.00
51.00	05100	RECOVERY ROOM	210	0	1,016,492	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	433,525	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	181,085	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,599,044	0	54.00
54.01	05401	ULTRASOUND	0	0	327,608	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	669,561	0	55.00
57.00	05700	CT SCAN	0	0	1,110,268	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	606,781	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	6,124,906	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	1,156,349	0	65.00
65.01	03950	SLEEP CLINIC	0	0	202,762	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	1,753,086	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	307,317	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	250,682	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,047,696	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,857,586	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	3,684,881	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	223,442	3,907,812	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,914	0	3,579,180	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	314	0	1,324,602	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	9,953	0	82,729	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	313,559	223,442	54,333,623	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	110,910	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	790,529	0	192.00
192.01	19201	PHYSICIAN CLINIC	0	0	150,550	0	192.01
192.02	19202	LIFELINE	0	0	1,236	0	192.02
192.03	19203	CREDIT UNION	0	0	49,092	0	192.03
192.04	19204	ENT	0	0	276,220	0	192.04
192.05	19205	HOSPITALIST	0	0	1,450,102	0	192.05
192.06	19206	ORTHO	0	0	885,625	0	192.06
192.07	19207	ATHLETIC TRAINERS	0	0	67,697	0	192.07
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	173,061	0	194.00
194.01	07951	MARKETING	0	0	296,929	0	194.01
194.02	07953	OCCUPATIONAL HEALTH	0	0	245,613	0	194.02
194.03	07952	PATHS EDUCATION	0	0	3,249	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	PHARMACY RESIDENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
194.04	07954 FOUNDATION	0	0	131,972	0	131,972	194.04
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	313,559	223,442	58,966,408	0	58,966,408	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	21,658	8,800	30,458	30,458 4.00
5.01 01160	COMMUNICATIONS	0	3,088	1,255	4,343	112 5.01
5.02 00550	DATA PROCESSING	0	35,839	14,562	50,401	941 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	64,922	26,379	91,301	178 5.03
5.04 00570	ADMINITTING	0	35,097	14,260	49,357	821 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	21,465	8,721	30,186	365 5.05
5.06 00591	OTHER ADMINISTRATIVE AND GENERAL	0	132,434	53,810	186,244	2,374 5.06
7.00 00700	OPERATION OF PLANT	0	991,360	402,802	1,394,162	798 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,172	6,571	22,743	89 8.00
9.00 00900	HOUSEKEEPING	0	11,967	4,862	16,829	849 9.00
10.00 01000	DIETARY	0	40,633	16,510	57,143	279 10.00
11.00 01100	CAFETERIA	0	28,819	11,710	40,529	484 11.00
13.00 01300	NURSING ADMINISTRATION	0	6,095	2,476	8,571	1,241 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	72,002	29,255	101,257	281 14.00
15.00 01500	PHARMACY	0	15,065	6,121	21,186	1,274 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	48,831	19,841	68,672	603 16.00
17.00 01700	SOCIAL SERVICE	0	2,286	929	3,215	236 17.00
23.00 02300	PHARMACY RESIDENCY	0	2,976	1,209	4,185	170 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	653,333	265,457	918,790	4,525 30.00
31.00 03100	INTENSIVE CARE UNIT	0	75,172	30,543	105,715	1,468 31.00
43.00 04300	NURSERY	0	4,063	1,651	5,714	450 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	261,943	106,430	368,373	1,544 50.00
51.00 05100	RECOVERY ROOM	0	11,814	4,800	16,614	633 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	5,120	2,080	7,200	265 52.00
53.00 05300	ANESTHESIOLOGY	0	163	66	229	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	119,127	48,403	167,530	1,055 54.00
54.01 05401	ULTRASOUND	0	6,298	2,559	8,857	191 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	11,733	4,767	16,500	358 55.00
57.00 05700	CT SCAN	0	0	0	0	510 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,157	3,314	11,471	238 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	68,264	27,736	96,000	2,078 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	11,824	4,804	16,628	725 65.00
65.01 03950	SLEEP CLINIC	0	0	0	0	0 65.01
66.00 06600	PHYSICAL THERAPY	0	76,838	31,220	108,058	1,087 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	8,066	3,277	11,343	217 67.00
68.00 06800	SPEECH PATHOLOGY	0	4,307	1,750	6,057	199 68.00
69.00 06900	ELECTROCARDIOLOGY	0	33,126	13,460	46,586	631 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						
91.00 09100	EMERGENCY	0	98,373	39,970	138,343	1,762 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	15,085	6,129	21,214	865 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	0	3,200	1,300	4,500	17 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,026,715	1,229,789	4,256,504	29,913 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,786	10,071	34,857	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	74 192.00
192.01 19201	PHYSICIAN CLINIC	0	17,269	7,017	24,286	10 192.01
192.02 19202	LIFELINE	0	0	0	0	0 192.02
192.03 19203	CREDIT UNION	0	10,626	4,317	14,943	0 192.03
192.04 19204	ENT	0	0	0	0	0 192.04
192.05 19205	HOSPITALIST	0	3,982	1,618	5,600	0 192.05
192.06 19206	ORTHO	0	0	0	0	0 192.06
192.07 19207	ATHLETIC TRAINERS	0	0	0	0	56 192.07
194.00 07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0 194.00
194.01 07951	MARKETING	0	9,396	3,818	13,214	138 194.01
194.02 07953	OCCUPATIONAL HEALTH	0	0	0	0	178 194.02

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
194.03 07952 PATHS EDUCATION	0	0	0	0	0	194.03
194.04 07954 FOUNDATION	0	5,739	2,332	8,071	89	194.04
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	3,098,513	1,258,962	4,357,475	30,458	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm		
Cost Center Description		COMMUNICATIONS	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE
		5.01	5.02	5.03	5.04	5.05
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	01160	4,455				5.01
5.02	00550	263	51,605			5.02
5.03	00560	51	617	92,147		5.03
5.04	00570	102	1,698	199	52,177	5.04
5.05	00580	183	2,675	38	0	33,447
5.06	00591	157	2,778	2,281	0	0
7.00	00700	153	720	594	0	0
8.00	00800	11	0	2,550	0	0
9.00	00900	66	257	750	0	0
10.00	01000	18	1,646	229	0	0
11.00	01100	62	0	0	0	0
13.00	01300	58	875	2,931	0	0
14.00	01400	69	1,080	1,825	0	0
15.00	01500	106	1,441	940	0	0
16.00	01600	267	2,778	129	0	0
17.00	01700	51	463	25	0	0
23.00	02300	26	154	103	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	526	9,161	3,676	38,380	2,109
31.00	03100	62	1,389	1,279	8,032	934
43.00	04300	0	0	0	5,765	77
44.00	04400	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	205	3,241	19,714	0	7,708
51.00	05100	58	0	644	0	503
52.00	05200	0	0	0	0	242
53.00	05300	26	0	3,112	0	762
54.00	05400	249	2,470	1,424	0	1,748
54.01	05401	7	0	220	0	365
55.00	05500	22	515	734	0	495
57.00	05700	0	0	1,072	0	2,950
58.00	05800	0	0	299	0	444
59.00	05900	0	0	0	0	0
60.00	06000	143	3,499	11,785	0	4,795
60.01	06001	0	0	0	0	0
65.00	06500	26	1,852	636	0	502
65.01	03950	18	0	70	0	81
66.00	06600	66	1,132	132	0	475
67.00	06700	40	0	46	0	144
68.00	06800	4	0	15	0	78
69.00	06900	135	0	143	0	952
71.00	07100	0	0	0	0	1,009
72.00	07200	0	0	32,692	0	1,691
73.00	07300	0	0	0	0	1,483
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	121	1,749	1,495	0	3,726
92.00	09200					
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	22	2,109	172	0	168
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	0	0	21	0	6
118.00		3,373	44,299	91,975	52,177	33,447
NONREIMBURSABLE COST CENTERS						
190.00	19000	18	0	0	0	0
192.00	19200	958	6,586	128	0	0
192.01	19201	33	463	8	0	0
192.02	19202	0	0	0	0	0
192.03	19203	40	0	0	0	0
192.04	19204	0	0	0	0	0
192.05	19205	0	206	6	0	0
192.06	19206	0	0	0	0	0
192.07	19207	0	0	0	0	0
194.00	07950	0	0	0	0	0
194.01	07951	11	51	14	0	0
194.02	07953	15	0	16	0	0
194.03	07952	0	0	0	0	0
194.04	07954	7	0	0	0	0
200.00						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086			Period: From 01/01/2020 To 10/31/2020		Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm	
Cost Center Description		COMMUNICATIONS 5.01	DATA PROCESSING 5.02	PURCHASING RECEIVING AND STORES 5.03	ADMINISTRATIVE 5.04	CASHIERING/AC COUNTS RECEIVABLE 5.05		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,455	51,605	92,147	52,177	33,447		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm	
Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 01160	COMMUNICATIONS					5.01
5.02 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMINISTRATIVE					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00591	OTHER ADMINISTRATIVE AND GENERAL	193,834				5.06
7.00 00700	OPERATION OF PLANT	13,071	1,409,498			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,317	12,716	39,426		8.00
9.00 00900	HOUSEKEEPING	3,940	9,409	0	32,100	9.00
10.00 01000	DIETARY	2,000	31,949	397	739	94,400 10.00
11.00 01100	CAFETERIA	1,876	22,660	688	524	0 11.00
13.00 01300	NURSING ADMINISTRATION	5,926	4,792	0	111	0 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	2,096	56,613	536	1,310	0 14.00
15.00 01500	PHARMACY	5,864	11,845	0	274	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,417	38,394	0	888	0 16.00
17.00 01700	SOCIAL SERVICE	985	1,797	0	42	0 17.00
23.00 02300	PHARMACY RESIDENCY	692	2,340	0	54	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	26,367	513,689	15,553	11,887	63,865 30.00
31.00 03100	INTENSIVE CARE UNIT	7,362	59,105	2,818	1,368	6,975 31.00
43.00 04300	NURSERY	2,345	3,195	0	74	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,679	205,956	4,749	4,765	0 50.00
51.00 05100	RECOVERY ROOM	2,794	9,289	0	215	103 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,192	4,026	0	93	0 52.00
53.00 05300	ANESTHESIOLOGY	503	128	0	3	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,992	93,665	2,522	2,167	0 54.00
54.01 05401	ULTRASOUND	926	4,952	864	115	0 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,993	9,225	205	213	0 55.00
57.00 05700	CT SCAN	3,300	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,864	6,414	0	148	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	18,655	53,674	9	1,242	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	3,532	9,297	722	215	0 65.00
65.01 03950	SLEEP CLINIC	657	0	0	0	0 65.01
66.00 06600	PHYSICAL THERAPY	4,848	60,415	675	1,398	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	896	6,342	97	147	0 67.00
68.00 06800	SPEECH PATHOLOGY	760	3,387	0	78	0 68.00
69.00 06900	ELECTROCARDIOLOGY	2,951	26,046	184	603	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,176	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	11,912	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,836	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	8,795	77,347	8,909	1,790	1,827 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	4,189	11,861	0	274	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	208	2,516	0	58	0 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	179,916	1,353,044	38,928	30,795	72,770 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	127	19,489	0	451	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,591	0	0	0	0 192.00
192.01 19201	PHYSICIAN CLINIC	327	13,578	0	314	0 192.01
192.02 19202	LIFELINE	4	0	0	0	0 192.02
192.03 19203	CREDIT UNION	60	8,355	0	193	0 192.03
192.04 19204	ENT	908	0	0	0	0 192.04
192.05 19205	HOSPITALIST	4,729	3,131	0	72	0 192.05
192.06 19206	ORTHO	2,911	0	0	0	0 192.06
192.07 19207	ATHLETIC TRAINERS	216	0	0	0	0 192.07
194.00 07950	COMMUNITY MENTAL HEALTH	0	0	498	0	21,630 194.00
194.01 07951	MARKETING	873	7,388	0	171	0 194.01
194.02 07953	OCCUPATIONAL HEALTH	790	0	0	0	0 194.02
194.03 07952	PATHS EDUCATION	11	0	0	0	0 194.03
194.04 07954	FOUNDATION	371	4,513	0	104	0 194.04
200.00	Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086			Period: From 01/01/2020 To 10/31/2020		Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm	
Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	193,834	1,409,498	39,426	32,100	94,400		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B
Part II
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	66,823					11.00
13.00	01300	3,193	27,698				13.00
14.00	01400	1,417	1,122	167,606			14.00
15.00	01500	2,810	0	0	45,740		15.00
16.00	01600	2,481	0	0	0	117,629	16.00
17.00	01700	732	0	0	0	0	17.00
23.00	02300	436	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,345	12,145	0	0	7,411	30.00
31.00	03100	4,404	3,487	0	0	3,284	31.00
43.00	04300	1,277	1,011	0	0	272	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,217	3,339	0	0	27,188	50.00
51.00	05100	1,797	1,423	0	0	1,768	51.00
52.00	05200	753	597	0	0	850	52.00
53.00	05300	0	0	0	0	2,678	53.00
54.00	05400	3,441	0	0	0	6,142	54.00
54.01	05401	489	0	0	0	1,283	54.01
55.00	05500	891	0	0	0	1,740	55.00
57.00	05700	0	0	0	0	10,366	57.00
58.00	05800	0	0	0	0	1,560	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	7,879	0	0	0	16,848	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	2,143	0	0	0	1,763	65.00
65.01	03950	0	0	0	0	283	65.01
66.00	06600	3,007	0	0	0	1,668	66.00
67.00	06700	509	0	0	0	507	67.00
68.00	06800	416	0	0	0	273	68.00
69.00	06900	1,735	0	0	0	3,345	69.00
71.00	07100	0	0	167,606	0	3,546	71.00
72.00	07200	0	0	0	0	5,942	72.00
73.00	07300	0	0	0	45,740	5,211	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	5,778	4,574	0	0	13,091	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	590	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	20	116.00
118.00		65,150	27,698	167,606	45,740	117,629	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	239	0	0	0	0	192.00
192.01	19201	64	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
192.07	19207	202	0	0	0	0	192.07
194.00	07950	0	0	0	0	0	194.00
194.01	07951	391	0	0	0	0	194.01
194.02	07953	523	0	0	0	0	194.02
194.03	07952	0	0	0	0	0	194.03
194.04	07954	254	0	0	0	0	194.04
200.00							200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086			Period: From 01/01/2020 To 10/31/2020		Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	66,823	27,698	167,606	45,740	117,629	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm		
Cost Center Description			SOCIAL SERVICE	PHARMACY RESIDENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			17.00	23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	7,546				17.00
23.00	02300	PHARMACY RESIDENCY	0	8,160			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,502		1,649,931	0	1,649,931 30.00
31.00	03100	INTENSIVE CARE UNIT	292		207,974	0	207,974 31.00
43.00	04300	NURSERY	0		20,180	0	20,180 43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	333		665,011	0	665,011 50.00
51.00	05100	RECOVERY ROOM	5		35,846	0	35,846 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		15,218	0	15,218 52.00
53.00	05300	ANESTHESIOLOGY	0		7,441	0	7,441 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		289,405	0	289,405 54.00
54.01	05401	ULTRASOUND	0		18,269	0	18,269 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		32,891	0	32,891 55.00
57.00	05700	CT SCAN	0		18,198	0	18,198 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		22,438	0	22,438 58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000	LABORATORY	0		216,607	0	216,607 60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0		38,041	0	38,041 65.00
65.01	03950	SLEEP CLINIC	0		1,109	0	1,109 65.01
66.00	06600	PHYSICAL THERAPY	0		182,961	0	182,961 66.00
67.00	06700	OCCUPATIONAL THERAPY	0		20,288	0	20,288 67.00
68.00	06800	SPEECH PATHOLOGY	0		11,267	0	11,267 68.00
69.00	06900	ELECTROCARDIOLOGY	0		83,311	0	83,311 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		178,337	0	178,337 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		52,237	0	52,237 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		58,270	0	58,270 73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	166		269,473	0	269,473 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	8		41,472	0	41,472 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	240		7,586	0	7,586 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,546	0	4,143,761	0	4,143,761 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		54,942	0	54,942 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		10,576	0	10,576 192.00
192.01	19201	PHYSICIAN CLINIC	0		39,083	0	39,083 192.01
192.02	19202	LIFELINE	0		4	0	4 192.02
192.03	19203	CREDIT UNION	0		23,591	0	23,591 192.03
192.04	19204	ENT	0		908	0	908 192.04
192.05	19205	HOSPITALIST	0		13,744	0	13,744 192.05
192.06	19206	ORTHO	0		2,911	0	2,911 192.06
192.07	19207	ATHLETIC TRAINERS	0		474	0	474 192.07
194.00	07950	COMMUNITY MENTAL HEALTH	0		22,128	0	22,128 194.00
194.01	07951	MARKETING	0		22,251	0	22,251 194.01
194.02	07953	OCCUPATIONAL HEALTH	0		1,522	0	1,522 194.02
194.03	07952	PATHS EDUCATION	0		11	0	11 194.03

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet B Part II Date/Time Prepared: 3/31/2021 12:34 pm			
Cost Center Description		SOCIAL SERVICE	PHARMACY RESIDENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
194.04	07954 FOUNDATION	0		13,409	0	13,409	194.04
200.00	Cross Foot Adjustments		8,160	8,160	0	8,160	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7,546	8,160	4,357,475	0	4,357,475	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	305,022				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		305,022			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,132	2,132	23,790,728		4.00
5.01 01160	COMMUNICATIONS	304	304	87,794	1,219	5.01
5.02 00550	DATA PROCESSING	3,528	3,528	735,012	72	1,003 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	6,391	6,391	139,028	14	12 5.03
5.04 00570	ADMITTING	3,455	3,455	641,282	28	33 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,113	2,113	285,243	50	52 5.05
5.06 00591	OTHER ADMINISTRATIVE AND GENERAL	13,037	13,037	1,854,930	43	54 5.06
7.00 00700	OPERATION OF PLANT	97,591	97,591	623,680	42	14 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,592	1,592	69,901	3	0 8.00
9.00 00900	HOUSEKEEPING	1,178	1,178	663,160	18	5 9.00
10.00 01000	DIETARY	4,000	4,000	218,215	5	32 10.00
11.00 01100	CAFETERIA	2,837	2,837	378,490	17	0 11.00
13.00 01300	NURSING ADMINISTRATION	600	600	969,807	16	17 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	7,088	7,088	219,567	19	21 14.00
15.00 01500	PHARMACY	1,483	1,483	995,007	29	28 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,807	4,807	471,302	73	54 16.00
17.00 01700	SOCIAL SERVICE	225	225	184,698	14	9 17.00
23.00 02300	PHARMACY RESIDENCY	293	293	133,171	7	3 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	64,315	64,315	3,528,190	144	178 30.00
31.00 03100	INTENSIVE CARE UNIT	7,400	7,400	1,146,640	17	27 31.00
43.00 04300	NURSERY	400	400	351,248	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,786	25,786	1,206,241	56	63 50.00
51.00 05100	RECOVERY ROOM	1,163	1,163	494,769	16	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	504	504	207,236	0	0 52.00
53.00 05300	ANESTHESIOLOGY	16	16	0	7	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,727	11,727	823,967	68	48 54.00
54.01 05401	ULTRASOUND	620	620	149,528	2	0 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,155	1,155	279,740	6	10 55.00
57.00 05700	CT SCAN	0	0	398,133	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	803	803	185,853	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	6,720	6,720	1,623,653	39	68 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	1,164	1,164	566,496	7	36 65.00
65.01 03950	SLEEP CLINIC	0	0	0	5	0 65.01
66.00 06600	PHYSICAL THERAPY	7,564	7,564	849,525	18	22 66.00
67.00 06700	OCCUPATIONAL THERAPY	794	794	169,698	11	0 67.00
68.00 06800	SPEECH PATHOLOGY	424	424	155,138	1	0 68.00
69.00 06900	ELECTROCARDIOLOGY	3,261	3,261	493,008	37	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						
91.00 09100	EMERGENCY	9,684	9,684	1,376,669	33	34 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	1,485	1,485	675,891	6	41 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	315	315	13,018	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	297,954	297,954	23,364,928	923	861 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,440	2,440	0	5	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	57,480	262	128 192.00
192.01 19201	PHYSICIAN CLINIC	1,700	1,700	7,776	9	9 192.01
192.02 19202	LIFELINE	0	0	0	0	0 192.02
192.03 19203	CREDIT UNION	1,046	1,046	0	11	0 192.03
192.04 19204	ENT	0	0	0	0	0 192.04
192.05 19205	HOSPITALIST	392	392	0	0	4 192.05
192.06 19206	ORTHO	0	0	0	0	0 192.06
192.07 19207	ATHLETIC TRAINERS	0	0	43,819	0	0 192.07
194.00 07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0 194.00
194.01 07951	MARKETING	925	925	107,982	3	1 194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description	CAPITAL RELATED COSTS					
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	
	1.00	2.00	4.00	5.01	5.02	
194.0207953 OCCUPATIONAL HEALTH	0	0	139,259	4	0	194.02
194.0307952 PATHS EDUCATION	0	0	0	0	0	194.03
194.0407954 FOUNDATION	565	565	69,484	2	0	194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	3,098,513	1,258,962	7,023,597	195,971	3,182,541	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.158326	4.127447	0.295224	160.763741	3,173.021934	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			30,458	4,455	51,605	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001280	3.654635	51.450648	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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMINITTING (ADMINISTRATIVE)	CASHIERING/ACCOUNTS RECEIVABLE (ADJUSTED CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)		
		5.03	5.04	5.05	5A.06	5.06		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	01160	COMMUNICATIONS					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00560	PURCHASING RECEIVING AND STORES	8,830,150				5.03	
5.04	00570	ADMINITTING	19,075	2,670			5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,634	0	184,825,045		5.05	
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	218,635	0	0	-4,657,038	5.06	
7.00	00700	OPERATION OF PLANT	56,912	0	0	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	244,390	0	0	0	8.00	
9.00	00900	HOUSEKEEPING	71,832	0	0	0	9.00	
10.00	01000	DIETARY	21,977	0	0	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	280,912	0	0	0	13.00	
14.00	01400	CENTRAL SERVICE & SUPPLY	174,863	0	0	0	14.00	
15.00	01500	PHARMACY	90,115	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	12,359	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	2,394	0	0	0	17.00	
23.00	02300	PHARMACY RESIDENCY	9,848	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	352,267	1,964	11,652,541	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	122,601	411	5,162,980	0	31.00	
43.00	04300	NURSERY	0	295	427,357	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,889,221	0	42,625,077	0	50.00	
51.00	05100	RECOVERY ROOM	61,673	0	2,779,269	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,336,350	0	52.00	
53.00	05300	ANESTHESIOLOGY	298,270	0	4,210,403	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,494	0	9,657,433	0	54.00	
54.01	05401	ULTRASOUND	21,082	0	2,017,809	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	70,325	0	2,735,237	0	55.00	
57.00	05700	CT SCAN	102,763	0	16,298,319	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,692	0	2,452,548	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	1,129,411	0	26,490,033	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	60,919	0	2,772,369	0	65.00	
65.01	03950	SLEEP CLINIC	6,692	0	445,551	0	65.01	
66.00	06600	PHYSICAL THERAPY	12,675	0	2,623,049	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,385	0	797,499	0	67.00	
68.00	06800	SPEECH PATHOLOGY	1,392	0	428,736	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	13,706	0	5,259,609	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,574,790	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,132,331	0	9,342,592	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,193,493	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	143,291	0	20,583,629	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	16,509	0	927,357	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	1,978	0	31,015	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,813,623	2,670	184,825,045	-4,657,038	50,409,744	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	35,661	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,238	0	0	0	725,909	192.00
192.01	19201	PHYSICIAN CLINIC	793	0	0	0	91,747	192.01
192.02	19202	LIFELINE	0	0	0	0	1,138	192.02
192.03	19203	CREDIT UNION	0	0	0	0	16,711	192.03
192.04	19204	ENT	0	0	0	0	254,405	192.04
192.05	19205	HOSPITALIST	593	0	0	0	1,324,894	192.05
192.06	19206	ORTHO	0	0	0	0	815,680	192.06
192.07	19207	ATHLETIC TRAINERS	0	0	0	0	60,503	192.07
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,366	0	0	0	244,705	194.01
194.02	07953	OCCUPATIONAL HEALTH	1,526	0	0	0	221,446	194.02
194.03	07952	PATHS EDUCATION	0	0	0	0	2,992	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (ADMISSIONS)	CASHIERING/AC COUNTS RECEIVABLE (ADJUSTED CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
194.04	07954 FOUNDATION						194.04
200.00	Cross Foot Adjustments	11	0	0	0	103,835	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	327,029	1,041,489	1,767,854		4,657,038	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.037035	390.070787	0.009565		0.085750	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	92,147	52,177	33,447		193,834	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.010435	19.541948	0.000181		0.003569	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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	176,471				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,592	313,302			8.00
9.00	00900	HOUSEKEEPING	1,178	0	173,701		9.00
10.00	01000	DIETARY	4,000	3,151	4,000	29,450	10.00
11.00	01100	CAFETERIA	2,837	5,465	2,837	0	553,312
13.00	01300	NURSING ADMINISTRATION	600	0	600	0	26,443
14.00	01400	CENTRAL SERVICE & SUPPLY	7,088	4,262	7,088	0	11,734
15.00	01500	PHARMACY	1,483	0	1,483	0	23,265
16.00	01600	MEDICAL RECORDS & LIBRARY	4,807	0	4,807	0	20,542
17.00	01700	SOCIAL SERVICE	225	0	225	0	6,062
23.00	02300	PHARMACY RESIDENCY	293	0	293	0	3,614
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	64,315	123,594	64,315	19,924	127,030
31.00	03100	INTENSIVE CARE UNIT	7,400	22,395	7,400	2,176	36,467
43.00	04300	NURSERY	400	0	400	0	10,575
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,786	37,742	25,786	0	34,920
51.00	05100	RECOVERY ROOM	1,163	0	1,163	32	14,882
52.00	05200	DELIVERY ROOM & LABOR ROOM	504	0	504	0	6,239
53.00	05300	ANESTHESIOLOGY	16	0	16	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,727	20,038	11,727	0	28,492
54.01	05401	ULTRASOUND	620	6,865	620	0	4,051
55.00	05500	RADIOLOGY-THERAPEUTIC	1,155	1,629	1,155	0	7,381
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	803	0	803	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	6,720	69	6,720	0	65,244
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,164	5,737	1,164	0	17,745
65.01	03950	SLEEP CLINIC	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	7,564	5,364	7,564	0	24,899
67.00	06700	OCCUPATIONAL THERAPY	794	768	794	0	4,213
68.00	06800	SPEECH PATHOLOGY	424	0	424	0	3,446
69.00	06900	ELECTROCARDIOLOGY	3,261	1,465	3,261	0	14,364
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,684	70,797	9,684	570	47,844
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,485	0	1,485	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	315	0	315	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,403	309,341	166,633	22,702	539,452
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,440	0	2,440	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,983
192.01	19201	PHYSICIAN CLINIC	1,700	0	1,700	0	534
192.02	19202	LIFELINE	0	0	0	0	0
192.03	19203	CREDIT UNION	1,046	0	1,046	0	0
192.04	19204	ENT	0	0	0	0	0
192.05	19205	HOSPITALIST	392	0	392	0	0
192.06	19206	ORTHO	0	0	0	0	0
192.07	19207	ATHLETIC TRAINERS	0	0	0	0	1,676
194.00	07950	COMMUNITY MENTAL HEALTH	0	3,961	0	6,748	0
194.01	07951	MARKETING	925	0	925	0	3,237
194.02	07953	OCCUPATIONAL HEALTH	0	0	0	0	4,327
194.03	07952	PATHS EDUCATION	0	0	0	0	0
194.04	07954	FOUNDATION	565	0	565	0	2,103

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.00	8.00	9.00	10.00	11.00	
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)	3,976,470	436,427	1,225,134	731,200	662,174	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22.533277	1.392991	7.053120	24.828523	1.196746	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,409,498	39,426	32,100	94,400	66,823	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.987137	0.125840	0.184800	3.205433	0.120769	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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		NURSING ADMINISTRATION (GROSS HOURS)	CENTRAL SERVICE & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (ADJUSTED CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	289,691					13.00
14.00	01400	11,734	100				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	184,825,045		16.00
17.00	01700	0	0	0	0	2,993	17.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	127,030	0	0	11,652,541	2,579	30.00
31.00	03100	36,467	0	0	5,162,980	116	31.00
43.00	04300	10,575	0	0	427,357	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	34,920	0	0	42,625,077	132	50.00
51.00	05100	14,882	0	0	2,779,269	2	51.00
52.00	05200	6,239	0	0	1,336,350	0	52.00
53.00	05300	0	0	0	4,210,403	0	53.00
54.00	05400	0	0	0	9,657,433	0	54.00
54.01	05401	0	0	0	2,017,809	0	54.01
55.00	05500	0	0	0	2,735,237	0	55.00
57.00	05700	0	0	0	16,298,319	0	57.00
58.00	05800	0	0	0	2,452,548	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	26,490,033	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	2,772,369	0	65.00
65.01	03950	0	0	0	445,551	0	65.01
66.00	06600	0	0	0	2,623,049	0	66.00
67.00	06700	0	0	0	797,499	0	67.00
68.00	06800	0	0	0	428,736	0	68.00
69.00	06900	0	0	0	5,259,609	0	69.00
71.00	07100	0	100	0	5,574,790	0	71.00
72.00	07200	0	0	0	9,342,592	0	72.00
73.00	07300	0	0	100	8,193,493	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	47,844	0	0	20,583,629	66	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	927,357	3	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	31,015	95	116.00
118.00		289,691	100	100	184,825,045	2,993	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
192.07	19207	0	0	0	0	0	192.07
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	0	0	0	0	0	194.02
194.03	07952	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1

Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		NURSING ADMINISTRATION (GROSS HOURS)	CENTRAL SERVICE & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (ADJUSTED CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
194.04	07954 FOUNDATION	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,852,274	942,284	1,855,498	1,206,180	313,559	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.393965	9,422.840000	18,554.980000	0.006526	104.764116	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	27,698	167,606	45,740	117,629	7,546	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.095612	1,676.060000	457.400000	0.000636	2.521216	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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		PHARMACY RESIDENCY (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	01160 COMMUNICATIONS		5.01
5.02	00550 DATA PROCESSING		5.02
5.03	00560 PURCHASING RECEIVING AND STORES		5.03
5.04	00570 ADMITTING		5.04
5.05	00580 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICE & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
23.00	02300 PHARMACY RESIDENCY	100	23.00
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
44.00	04400 SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401 ULTRASOUND	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	65.00
65.01	03950 SLEEP CLINIC	0	65.01
66.00	06600 PHYSICAL THERAPY	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	100	73.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 PHYSICIAN CLINIC	0	192.01
192.02	19202 LIFELINE	0	192.02
192.03	19203 CREDIT UNION	0	192.03
192.04	19204 ENT	0	192.04
192.05	19205 HOSPITALIST	0	192.05
192.06	19206 ORTHO	0	192.06
192.07	19207 ATHLETIC TRAINERS	0	192.07
194.00	07950 COMMUNITY MENTAL HEALTH	0	194.00
194.01	07951 MARKETING	0	194.01
194.02	07953 OCCUPATIONAL HEALTH	0	194.02
194.03	07952 PATHS EDUCATION	0	194.03
194.04	07954 FOUNDATION	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		PHARMACY RESIDENCY (ASSIGNED TIME)	
		23.00	
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)	223,442	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2,234.420000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	8,160	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	81.600000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet C
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	11,900,897		11,900,897	0	11,900,897 30.00
31.00	03100 INTENSIVE CARE UNIT	2,866,580		2,866,580	0	2,866,580 31.00
43.00	04300 NURSERY	808,170		808,170	0	808,170 43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,534,024		5,534,024	0	5,534,024 50.00
51.00	05100 RECOVERY ROOM	1,016,492		1,016,492	0	1,016,492 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	433,525		433,525	0	433,525 52.00
53.00	05300 ANESTHESIOLOGY	181,085		181,085	0	181,085 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,599,044		2,599,044	0	2,599,044 54.00
54.01	05401 ULTRASOUND	327,608		327,608	0	327,608 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	669,561		669,561	0	669,561 55.00
57.00	05700 CT SCAN	1,110,268		1,110,268	0	1,110,268 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	606,781		606,781	0	606,781 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	6,124,906		6,124,906	133,622	6,258,528 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	1,156,349	0	1,156,349	3,638	1,159,987 65.00
65.01	03950 SLEEP CLINIC	202,762	0	202,762	0	202,762 65.01
66.00	06600 PHYSICAL THERAPY	1,753,086	0	1,753,086	0	1,753,086 66.00
67.00	06700 OCCUPATIONAL THERAPY	307,317	0	307,317	0	307,317 67.00
68.00	06800 SPEECH PATHOLOGY	250,682	0	250,682	0	250,682 68.00
69.00	06900 ELECTROCARDIOLOGY	1,047,696		1,047,696	0	1,047,696 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,857,586		2,857,586	0	2,857,586 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,684,881		3,684,881	0	3,684,881 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,907,812		3,907,812	0	3,907,812 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	3,579,180		3,579,180	50,398	3,629,578 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,688,938		1,688,938		1,688,938 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,324,602		1,324,602		1,324,602 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	82,729		82,729		82,729 116.00
200.00	Subtotal (see instructions)	56,022,561	0	56,022,561	187,658	56,210,219 200.00
201.00	Less Observation Beds	1,688,938		1,688,938		1,688,938 201.00
202.00	Total (see instructions)	54,333,623	0	54,333,623	187,658	54,521,281 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet C Part I Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,972,971		9,972,971	30.00
31.00	03100	INTENSIVE CARE UNIT	5,162,980		5,162,980	31.00
43.00	04300	NURSERY	427,357		427,357	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,740,367	28,884,710	42,625,077	0.129830 50.00
51.00	05100	RECOVERY ROOM	545,601	2,233,668	2,779,269	0.365741 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,206,477	129,873	1,336,350	0.324410 52.00
53.00	05300	ANESTHESIOLOGY	1,219,433	2,990,970	4,210,403	0.043009 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,987	8,075,446	9,657,433	0.269124 54.00
54.01	05401	ULTRASOUND	232,649	1,785,160	2,017,809	0.162358 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,279,051	1,456,186	2,735,237	0.244791 55.00
57.00	05700	CT SCAN	3,435,695	12,862,624	16,298,319	0.068122 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,607	2,233,941	2,452,548	0.247408 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000 59.00
60.00	06000	LABORATORY	6,471,224	20,018,809	26,490,033	0.231215 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000 60.01
65.00	06500	RESPIRATORY THERAPY	2,306,759	465,610	2,772,369	0.417098 65.00
65.01	03950	SLEEP CLINIC	0	445,551	445,551	0.455081 65.01
66.00	06600	PHYSICAL THERAPY	638,142	1,984,907	2,623,049	0.668339 66.00
67.00	06700	OCCUPATIONAL THERAPY	452,076	345,423	797,499	0.385351 67.00
68.00	06800	SPEECH PATHOLOGY	148,699	280,037	428,736	0.584700 68.00
69.00	06900	ELECTROCARDIOLOGY	1,365,890	3,893,719	5,259,609	0.199197 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,414,631	2,160,159	5,574,790	0.512591 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,636,521	4,706,071	9,342,592	0.394417 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,161,235	3,032,258	8,193,493	0.476941 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,727,119	16,856,510	20,583,629	0.173885 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	793,665	885,905	1,679,570	1.005578 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	927,357	927,357	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	31,015	31,015	116.00
200.00		Subtotal (see instructions)	68,139,136	116,685,909	184,825,045	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	68,139,136	116,685,909	184,825,045	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet C
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.129830			50.00
51.00	05100 RECOVERY ROOM	0.365741			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.324410			52.00
53.00	05300 ANESTHESIOLOGY	0.043009			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269124			54.00
54.01	05401 ULTRASOUND	0.162358			54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.244791			55.00
57.00	05700 CT SCAN	0.068122			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.247408			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.236260			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.418410			65.00
65.01	03950 SLEEP CLINIC	0.455081			65.01
66.00	06600 PHYSICAL THERAPY	0.668339			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.385351			67.00
68.00	06800 SPEECH PATHOLOGY	0.584700			68.00
69.00	06900 ELECTROCARDIOLOGY	0.199197			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512591			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.394417			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.476941			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.176333			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.005578			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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet C
Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	11,900,897		11,900,897	0	11,900,897 30.00
31.00	03100 INTENSIVE CARE UNIT	2,866,580		2,866,580	0	2,866,580 31.00
43.00	04300 NURSERY	808,170		808,170	0	808,170 43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,534,024		5,534,024	0	5,534,024 50.00
51.00	05100 RECOVERY ROOM	1,016,492		1,016,492	0	1,016,492 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	433,525		433,525	0	433,525 52.00
53.00	05300 ANESTHESIOLOGY	181,085		181,085	0	181,085 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,599,044		2,599,044	0	2,599,044 54.00
54.01	05401 ULTRASOUND	327,608		327,608	0	327,608 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	669,561		669,561	0	669,561 55.00
57.00	05700 CT SCAN	1,110,268		1,110,268	0	1,110,268 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	606,781		606,781	0	606,781 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	6,124,906		6,124,906	133,622	6,258,528 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	1,156,349	0	1,156,349	3,638	1,159,987 65.00
65.01	03950 SLEEP CLINIC	202,762	0	202,762	0	202,762 65.01
66.00	06600 PHYSICAL THERAPY	1,753,086	0	1,753,086	0	1,753,086 66.00
67.00	06700 OCCUPATIONAL THERAPY	307,317	0	307,317	0	307,317 67.00
68.00	06800 SPEECH PATHOLOGY	250,682	0	250,682	0	250,682 68.00
69.00	06900 ELECTROCARDIOLOGY	1,047,696		1,047,696	0	1,047,696 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,857,586		2,857,586	0	2,857,586 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,684,881		3,684,881	0	3,684,881 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,907,812		3,907,812	0	3,907,812 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	3,579,180		3,579,180	50,398	3,629,578 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,688,938		1,688,938		1,688,938 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,324,602		1,324,602		1,324,602 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	82,729		82,729		82,729 116.00
200.00	Subtotal (see instructions)	56,022,561	0	56,022,561	187,658	56,210,219 200.00
201.00	Less Observation Beds	1,688,938		1,688,938		1,688,938 201.00
202.00	Total (see instructions)	54,333,623	0	54,333,623	187,658	54,521,281 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet C Part I Date/Time Prepared: 3/31/2021 12:34 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,972,971		9,972,971		30.00	
31.00	03100	INTENSIVE CARE UNIT	5,162,980		5,162,980		31.00	
43.00	04300	NURSERY	427,357		427,357		43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,740,367	28,884,710	42,625,077	0.129830	50.00	
51.00	05100	RECOVERY ROOM	545,601	2,233,668	2,779,269	0.365741	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,206,477	129,873	1,336,350	0.324410	52.00	
53.00	05300	ANESTHESIOLOGY	1,219,433	2,990,970	4,210,403	0.043009	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,987	8,075,446	9,657,433	0.269124	54.00	
54.01	05401	ULTRASOUND	232,649	1,785,160	2,017,809	0.162358	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,279,051	1,456,186	2,735,237	0.244791	55.00	
57.00	05700	CT SCAN	3,435,695	12,862,624	16,298,319	0.068122	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,607	2,233,941	2,452,548	0.247408	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00	
60.00	06000	LABORATORY	6,471,224	20,018,809	26,490,033	0.231215	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01	
65.00	06500	RESPIRATORY THERAPY	2,306,759	465,610	2,772,369	0.417098	65.00	
65.01	03950	SLEEP CLINIC	0	445,551	445,551	0.455081	65.01	
66.00	06600	PHYSICAL THERAPY	638,142	1,984,907	2,623,049	0.668339	66.00	
67.00	06700	OCCUPATIONAL THERAPY	452,076	345,423	797,499	0.385351	67.00	
68.00	06800	SPEECH PATHOLOGY	148,699	280,037	428,736	0.584700	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,365,890	3,893,719	5,259,609	0.199197	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,414,631	2,160,159	5,574,790	0.512591	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,636,521	4,706,071	9,342,592	0.394417	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,161,235	3,032,258	8,193,493	0.476941	73.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,727,119	16,856,510	20,583,629	0.173885	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	793,665	885,905	1,679,570	1.005578	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	927,357	927,357		101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	0	31,015	31,015		116.00	
200.00		Subtotal (see instructions)	68,139,136	116,685,909	184,825,045		200.00	
201.00		Less Observation Beds					201.00	
202.00		Total (see instructions)	68,139,136	116,685,909	184,825,045		202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet C Part I Date/Time Prepared: 3/31/2021 12:34 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
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
65.01	03950 SLEEP CLINIC	0.000000		65.01
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				
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 ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet D Part I Date/Time Prepared: 3/31/2021 12:34 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,649,931	0	1,649,931	7,448	221.53	30.00
31.00	INTENSIVE CARE UNIT	207,974		207,974	1,679	123.87	31.00
43.00	NURSERY	20,180		20,180	500	40.36	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,878,085		1,878,085	9,627		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,181	704,687				
31.00	INTENSIVE CARE UNIT	740	91,664				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	3,921	796,351				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part II Date/Time Prepared: 3/31/2021 12:34 pm
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	665,011	42,625,077	0.015601	6,239,971	97,350	50.00
51.00	05100 RECOVERY ROOM	35,846	2,779,269	0.012898	244,025	3,147	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15,218	1,336,350	0.011388	8,453	96	52.00
53.00	05300 ANESTHESIOLOGY	7,441	4,210,403	0.001767	603,742	1,067	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	289,405	9,657,433	0.029967	510,823	15,308	54.00
54.01	05401 ULTRASOUND	18,269	2,017,809	0.009054	100,582	911	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	32,891	2,735,237	0.012025	806,788	9,702	55.00
57.00	05700 CT SCAN	18,198	16,298,319	0.001117	2,009,712	2,245	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	22,438	2,452,548	0.009149	115,955	1,061	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	216,607	26,490,033	0.008177	3,457,786	28,274	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	38,041	2,772,369	0.013721	1,126,154	15,452	65.00
65.01	03950 SLEEP CLINIC	1,109	445,551	0.002489	0	0	65.01
66.00	06600 PHYSICAL THERAPY	182,961	2,623,049	0.069751	369,670	25,785	66.00
67.00	06700 OCCUPATIONAL THERAPY	20,288	797,499	0.025440	269,507	6,856	67.00
68.00	06800 SPEECH PATHOLOGY	11,267	428,736	0.026280	95,077	2,499	68.00
69.00	06900 ELECTROCARDIOLOGY	83,311	5,259,609	0.015840	1,081,955	17,138	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	178,337	5,574,790	0.031990	1,781,011	56,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	52,237	9,342,592	0.005591	2,469,989	13,810	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	58,270	8,193,493	0.007112	2,522,361	17,939	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	269,473	20,583,629	0.013092	2,164,346	28,336	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	234,153	1,679,570	0.139412	755,841	105,373	92.00
200.00	Total (lines 50 through 199)	2,450,771	168,303,365		26,733,748	449,324	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part III Date/Time Prepared: 3/31/2021 12:34 pm
Title XVIII			Hospital	PPS

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	7,448	0.00	3,181	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	1,679	0.00	740	31.00	
43.00	04300	NURSERY	0	0	500	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)	0	0	9,627		3,921	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part IV Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description	Title XVIII			Hospital		PPS	
	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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03950	SLEEP CLINIC	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	223,442	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	223,442	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part IV Date/Time Prepared: 3/31/2021 12:34 pm
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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)	Title XVIII		Hospital	
				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	42,625,077	0.000000	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	2,779,269	0.000000	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1,336,350	0.000000	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	4,210,403	0.000000	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	9,657,433	0.000000	54.00	
54.01 05401 ULTRASOUND	0	0	0	2,017,809	0.000000	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	2,735,237	0.000000	55.00	
57.00 05700 CT SCAN	0	0	0	16,298,319	0.000000	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,452,548	0.000000	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00	
60.00 06000 LABORATORY	0	0	0	26,490,033	0.000000	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01	
65.00 06500 RESPIRATORY THERAPY	0	0	0	2,772,369	0.000000	65.00	
65.01 03950 SLEEP CLINIC	0	0	0	445,551	0.000000	65.01	
66.00 06600 PHYSICAL THERAPY	0	0	0	2,623,049	0.000000	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	797,499	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	428,736	0.000000	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	5,259,609	0.000000	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,574,790	0.000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,342,592	0.000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	223,442	223,442	8,193,493	0.027271	73.00	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0	0	0	20,583,629	0.000000	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,679,570	0.000000	92.00	
200.00 Total (lines 50 through 199)	0	223,442	223,442	168,303,365		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part IV Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description		Title XVIII				Hospital		PPS
		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	6,239,971	0	6,210,881	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	244,025	0	682,644	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	8,453	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	603,742	0	641,832	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	510,823	0	2,226,571	0	54.00	
54.01	05401 ULTRASOUND	0.000000	100,582	0	309,406	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	806,788	0	336,536	0	55.00	
57.00	05700 CT SCAN	0.000000	2,009,712	0	3,580,267	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	115,955	0	628,267	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	3,457,786	0	1,563,961	0	60.00	
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
65.00	06500 RESPIRATORY THERAPY	0.000000	1,126,154	0	122,991	0	65.00	
65.01	03950 SLEEP CLINIC	0.000000	0	0	136,177	0	65.01	
66.00	06600 PHYSICAL THERAPY	0.000000	369,670	0	10,849	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	269,507	0	9,675	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	95,077	0	2,434	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,081,955	0	1,577,187	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,781,011	0	436,960	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	2,469,989	0	955,639	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.027271	2,522,361	68,787	904,437	24,665	73.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0.000000	2,164,346	0	2,823,193	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	755,841	0	879,062	0	92.00	
200.00	Total (lines 50 through 199)		26,733,748	68,787	24,038,969	24,665	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part V Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.129830	6,210,881	0	0	806,359	50.00
51.00	05100	RECOVERY ROOM	0.365741	682,644	0	0	249,671	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324410	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.043009	641,832	0	0	27,605	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269124	2,226,571	0	0	599,224	54.00
54.01	05401	ULTRASOUND	0.162358	309,406	0	0	50,235	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244791	336,536	0	0	82,381	55.00
57.00	05700	CT SCAN	0.068122	3,580,267	0	0	243,895	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.247408	628,267	0	0	155,438	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.231215	1,563,961	0	0	361,611	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.417098	122,991	0	0	51,299	65.00
65.01	03950	SLEEP CLINIC	0.455081	136,177	0	0	61,972	65.01
66.00	06600	PHYSICAL THERAPY	0.668339	10,849	0	0	7,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.385351	9,675	0	0	3,728	67.00
68.00	06800	SPEECH PATHOLOGY	0.584700	2,434	0	0	1,423	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199197	1,577,187	0	0	314,171	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512591	436,960	0	0	223,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.394417	955,639	0	0	376,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476941	904,437	0	674	431,363	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.173885	2,823,193	0	0	490,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.005578	879,062	0	0	883,965	92.00
200.00		Subtotal (see instructions)		24,038,969	0	674	5,423,404	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		24,038,969	0	674	5,423,404	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D Part V Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS

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	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
65.01	03950 SLEEP CLINIC	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	321	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	321	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	321	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-1 Date/Time Prepared: 3/31/2021 12:34 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,448	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,448	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)		6,391	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)		3,181	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		11,900,897	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)		11,900,897	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)		11,900,897	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)		1,597.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,082,793	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,082,793	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-1 Date/Time Prepared: 3/31/2021 12:34 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	2,866,580	1,679	1,707.31	740	1,263,409	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)					7,587,007	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,933,209	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)					796,351	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					518,111	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,314,462	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					12,618,747	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)					1,057	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,597.86	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,688,938	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet D-1 Date/Time Prepared: 3/31/2021 12:34 pm	
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	1,649,931	11,900,897	0.138639	1,688,938	234,153	90.00
91.00	Nursing School cost	0	11,900,897	0.000000	1,688,938	0	91.00
92.00	Allied health cost	0	11,900,897	0.000000	1,688,938	0	92.00
93.00	All other Medical Education	0	11,900,897	0.000000	1,688,938	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-1 Date/Time Prepared: 3/31/2021 12:34 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,448 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,448 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)			6,391 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)			309 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)			500 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			11,900,897 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)			11,900,897 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)			11,900,897 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)			1,597.86 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			493,739 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)			493,739 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-1 Date/Time Prepared: 3/31/2021 12:34 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)	808,170	500	1,616.34	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	2,866,580	1,679	1,707.31	0	0
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)					369,180
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					862,919
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					1,057
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,597.86
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,688,938

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet D-1 Date/Time Prepared: 3/31/2021 12:34 pm	
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	1,649,931	11,900,897	0.138639	1,688,938	234,153	90.00
91.00	Nursing School cost	0	11,900,897	0.000000	1,688,938	0	91.00
92.00	Allied health cost	0	11,900,897	0.000000	1,688,938	0	92.00
93.00	All other Medical Education	0	11,900,897	0.000000	1,688,938	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-3 Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,306,855	30.00
31.00	03100	INTENSIVE CARE UNIT		2,132,969	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.129830	6,239,971	810,135 50.00
51.00	05100	RECOVERY ROOM	0.365741	244,025	89,250 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324410	8,453	2,742 52.00
53.00	05300	ANESTHESIOLOGY	0.043009	603,742	25,966 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269124	510,823	137,475 54.00
54.01	05401	ULTRASOUND	0.162358	100,582	16,330 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244791	806,788	197,494 55.00
57.00	05700	CT SCAN	0.068122	2,009,712	136,906 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.247408	115,955	28,688 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.236260	3,457,786	816,937 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.418410	1,126,154	471,194 65.00
65.01	03950	SLEEP CLINIC	0.455081	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.668339	369,670	247,065 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.385351	269,507	103,855 67.00
68.00	06800	SPEECH PATHOLOGY	0.584700	95,077	55,592 68.00
69.00	06900	ELECTROCARDIOLOGY	0.199197	1,081,955	215,522 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512591	1,781,011	912,930 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.394417	2,469,989	974,206 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476941	2,522,361	1,203,017 73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.176333	2,164,346	381,646 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.005578	755,841	760,057 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,733,748	7,587,007 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		26,733,748	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-3 Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		356,197	30.00
31.00	03100	INTENSIVE CARE UNIT		101,965	31.00
43.00	04300	NURSERY		21,069	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.129830	416,695	54,100 50.00
51.00	05100	RECOVERY ROOM	0.365741	29,050	10,625 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324410	47,793	15,505 52.00
53.00	05300	ANESTHESIOLOGY	0.043009	48,844	2,101 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269124	37,828	10,180 54.00
54.01	05401	ULTRASOUND	0.162358	9,467	1,537 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.244791	20,130	4,928 55.00
57.00	05700	CT SCAN	0.068122	162,808	11,091 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.247408	9,884	2,445 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.231215	222,368	51,415 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.417098	104,678	43,661 65.00
65.01	03950	SLEEP CLINIC	0.455081	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.668339	11,139	7,445 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.385351	4,722	1,820 67.00
68.00	06800	SPEECH PATHOLOGY	0.584700	5,863	3,428 68.00
69.00	06900	ELECTROCARDIOLOGY	0.199197	30,030	5,982 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512591	12,563	6,440 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.394417	90,484	35,688 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476941	177,668	84,737 73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.173885	92,312	16,052 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.005578	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,534,326	369,180 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		1,534,326	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E Part A Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		7,514,367	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		977,768	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		431,419	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		8,883	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		58.53	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.93	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.67	31.00
32.00	Sum of lines 30 and 31		23.60	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.68	33.00
34.00	Disproportionate share adjustment (see instructions)		184,280	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E Part A Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000102247	0.000117476	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	853,827	973,876	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	639,204	82,713	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	721,917		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	9,838,634		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		9,838,634	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		740,559	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		68,787	58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,647,980	59.00
60.00	Primary payer payments		14,208	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,633,772	61.00
62.00	Deductibles billed to program beneficiaries		1,023,220	62.00
63.00	Coinurance billed to program beneficiaries		36,608	63.00
64.00	Allowable bad debts (see instructions)		48,330	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		31,415	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,516	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,605,359	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-5,523	70.93
70.94	HRR adjustment amount (see instructions)		-137,265	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E Part A Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	507,341	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	76,799	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		97,845	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,948,866	71.00
71.01	Sequestration adjustment (see instructions)		78,596	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		9,742,280	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		127,990	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		242,456	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/31/2021 12:34 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,514,367	0	7,514,367	7,514,367	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	977,768	0	977,768	977,768	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00					2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	431,419	0	431,419	431,419	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8,883	0	8,883	8,883	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0868	0.0868	0.0868	0.0868	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	184,280	0	163,062	21,218	11.00	
11.01	Uncompensated care payments	36.00	721,917	0	639,204	82,713	11.01	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	9,838,634	0	8,748,052	1,090,582	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,838,634	0	8,748,052	1,090,582	15.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/31/2021 12:34 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	740,559	0	664,574	75,985	740,559	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,412,626	1,166,567	10,579,193	19.00
	W/S L, line	(Amounts from L)						
	0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	662,815	0	588,314	74,501	662,815	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	77,744	0	76,260	1,484	77,744	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	740,559	0	664,574	75,985	740,559	26.00
	W/S E, Part A line	(Amounts to E, Part A)						
	0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor			0.053900	0.065833			27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96		507,341			507,341	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97			76,799		76,799	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2021 12:34 pm
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		Title XVIII			Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,514,367	7,514,367		7,514,367	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	977,768		977,768	977,768	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00					2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	431,419	431,419		431,419	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8,883		8,883	8,883	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0868	0.0868	0.0868		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	184,280	163,062	21,218	184,280	11.00	
11.01	Uncompensated care payments	36.00	721,917	639,204	82,713	721,917	11.01	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	9,838,634	8,748,052	1,090,582	9,838,634	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,838,634	8,748,052	1,090,582	9,838,634	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	740,559	664,574	75,985	740,559	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
17.01	Net organ acquisition cost						17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			9,412,626	1,166,567	10,579,193	19.00	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	662,815	588,314	74,501	662,815	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	77,744	76,260	1,484	77,744	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	740,559	664,574	75,985	740,559	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	507,341	507,341		507,341	27.00
28.00	Low volume adjustment prior to October 1	70.97	76,799		76,799	76,799	28.00
30.00	HVBP payment adjustment (see instructions)	70.93	-5,523	-6,250	727	-5,523	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-137,265	-129,247	-8,018	-137,265	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		97,845		97,845	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E Part B Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		321	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,398,739	2.00
3.00	OPPS payments		4,023,606	3.00
4.00	Outlier payment (see instructions)		91,173	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		24,665	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		321	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		674	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)		674	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 charge basis 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)		674	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		353	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)		321	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)		4,139,444	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		835,867	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,303,898	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,303,898	30.00
31.00	Primary payer payments		394	31.00
32.00	Subtotal (line 30 minus line 31)		3,303,504	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)		83,381	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		54,198	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,332	36.00
37.00	Subtotal (see instructions)		3,357,702	37.00
38.00	MSP-LCC reconciliation amount from PS&R		51	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,357,651	40.00
40.01	Sequestration adjustment (see instructions)		26,525	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		3,381,677	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)		-50,551	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: 15-0086		Period: From 01/01/2020 To 10/31/2020		Worksheet E-1 Part I Date/Time Prepared: 3/31/2021 12:34 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,602,320		3,253,857	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	07/10/2020	52,500	10/31/2020	127,820		3.01
3.02		10/31/2020	87,460		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)		139,960		127,820		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)		9,742,280		3,381,677		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		127,990		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		50,551		6.02
7.00	Total Medicare program liability (see instructions)		9,870,270		3,331,126		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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E-1 Part II Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Hospital	PPS
				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		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 3/31/2021 12:34 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		862,919		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)		862,919	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)		862,919	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		479,231		8.00
9.00	Ancillary service charges		1,534,326	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)		2,013,557	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)		2,013,557	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,150,638	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)		862,919	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)		862,919	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)		862,919	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		862,919	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		862,919	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)		862,919	0	40.00
41.00	Interim payments		976,950	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-114,031	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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet G

Date/Time Prepared:
3/31/2021 12:34 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	11,934,121	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	71,759,694	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,542,125	0	0	0	6.00
7.00	Inventory	1,504,348	0	0	0	7.00
8.00	Prepaid expenses	20,596	0	0	0	8.00
9.00	Other current assets	1,462,655	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)	60,139,289	0	0	0	11.00
FIXED ASSETS						
12.00	Land	75,208	0	0	0	12.00
13.00	Land improvements	1,548,970	0	0	0	13.00
14.00	Accumulated depreciation	-1,378,788	0	0	0	14.00
15.00	Buildings	57,283,306	0	0	0	15.00
16.00	Accumulated depreciation	-39,738,200	0	0	0	16.00
17.00	Leasehold improvements	12,136,721	0	0	0	17.00
18.00	Accumulated depreciation	-9,662,454	0	0	0	18.00
19.00	Fixed equipment	18,642,045	0	0	0	19.00
20.00	Accumulated depreciation	-15,153,795	0	0	0	20.00
21.00	Automobiles and trucks	277,439	0	0	0	21.00
22.00	Accumulated depreciation	-250,656	0	0	0	22.00
23.00	Major movable equipment	38,169,509	0	0	0	23.00
24.00	Accumulated depreciation	-32,814,449	0	0	0	24.00
25.00	Minor equipment depreciable	4,775	0	0	0	25.00
26.00	Accumulated depreciation	-4,775	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)	29,134,856	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	24,546,564	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,546,564	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	113,820,709	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,066,502	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-19	0	0	0	38.00
39.00	Payroll taxes payable	644,995	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	0	0	0	42.00
43.00	Due to other funds	52,593,513	0	0	0	43.00
44.00	Other current liabilities	1,273,662	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	59,578,653	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,644,975	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,644,975	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	64,223,628	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	49,597,081				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)	49,597,081	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	113,820,709	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet G-1

Date/Time Prepared:
3/31/2021 12:34 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		50,631,596			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,036,802				2.00
3.00	Total (sum of line 1 and line 2)		49,594,794			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	IMMATERIAL ADJUSTMENT	2,287		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)		2,287			0	10.00
11.00	Subtotal (line 3 plus line 10)		49,597,081			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)		49,597,081			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	IMMATERIAL ADJUSTMENT		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: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet G-2
Parts I & II
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,595,916		10,595,916	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,595,916		10,595,916	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,162,980		5,162,980	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)	5,162,980		5,162,980	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,758,896		15,758,896	17.00
18.00	Ancillary services	48,055,044	97,985,122	146,040,166	18.00
19.00	Outpatient services	4,926,101	17,141,510	22,067,611	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		927,357	927,357	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	31,015	31,015	26.00
27.00	OCCUPATIONAL HEALTH	0	221,810	221,810	27.00
27.01	PROFESSIONAL FEES	0	999,876	999,876	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	68,740,041	117,306,690	186,046,731	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		67,531,939		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)		67,531,939		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet G-3

Date/Time Prepared:
3/31/2021 12:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	186,046,731	1.00
2.00	Less contractual allowances and discounts on patients' accounts	128,730,762	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,315,969	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	67,531,939	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,215,970	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 REVENUE	4,335,570	24.00
24.01	OTHER NON-OPERATING REVENUE	-6,830,868	24.01
24.50	COVID-19 PHE Funding	11,674,466	24.50
25.00	Total other income (sum of lines 6-24)	9,179,168	25.00
26.00	Total (line 5 plus line 25)	-1,036,802	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,036,802	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet H

HHA CCN: 15-7055

To 10/31/2020

Date/Time Prepared: 3/31/2021 12:34 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	158,487	47,487	69,647	19,341	294,962	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	326,546	0	0	0	326,546	6.00
7.00	Physical Therapy	151,573	0	0	0	151,573	7.00
8.00	Occupational Therapy	16,396	0	0	0	16,396	8.00
9.00	Speech Pathology	3,220	0	0	0	3,220	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	19,669	0	0	0	19,669	11.00
12.00	Supplies (see instructions)	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	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	675,891	47,487	69,647	19,341	812,366	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	294,962	0	294,962		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	326,546	0	326,546		6.00
7.00	Physical Therapy	0	151,573	0	151,573		7.00
8.00	Occupational Therapy	0	16,396	0	16,396		8.00
9.00	Speech Pathology	0	3,220	0	3,220		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	19,669	0	19,669		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	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	812,366	0	812,366		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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet H-1 Part I Date/Time Prepared: 3/31/2021 12:34 pm
		HHA CCN: 15-7055	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
	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	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	294,962	0	0	0	294,962	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	326,546	0	0	0	326,546	6.00	
7.00	Physical Therapy	151,573	0	0	0	151,573	7.00	
8.00	Occupational Therapy	16,396	0	0	0	16,396	8.00	
9.00	Speech Pathology	3,220	0	0	0	3,220	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	19,669	0	0	0	19,669	11.00	
12.00	Supplies (see instructions)	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	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Tel emedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	812,366	0	0	0	812,366	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	294,962					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	186,157	512,703				6.00
7.00	Physical Therapy	86,409	237,982				7.00
8.00	Occupational Therapy	9,347	25,743				8.00
9.00	Speech Pathology	1,836	5,056				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	11,213	30,882				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	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		812,366				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet H-1

HHA CCN: 15-7055

To 10/31/2020

Part II
Date/Time Prepared:
3/31/2021 12:34 pm

Home Health Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
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	-294,962	517,404
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	326,546
7.00	Physical Therapy	0	0	0	0	0	151,573
8.00	Occupational Therapy	0	0	0	0	0	16,396
9.00	Speech Pathology	0	0	0	0	0	3,220
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	19,669
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-294,962	517,404
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	294,962
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.570081

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet H-2

HHA CCN: 15-7055

To 10/31/2020

Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		1.00	2.00				
1.00 Administrative and General	0	15,085	6,129	199,539	965	130,094	1.00
2.00 Skilled Nursing Care	512,703	0	0	0	0	0	2.00
3.00 Physical Therapy	237,982	0	0	0	0	0	3.00
4.00 Occupational Therapy	25,743	0	0	0	0	0	4.00
5.00 Speech Pathology	5,056	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	30,882	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)	812,366	15,085	6,129	199,539	965	130,094	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	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
	5.03	5.04	5.05	5A.05	5.06	7.00	
1.00 Administrative and General	611	0	8,870	361,293	30,981	33,462	1.00
2.00 Skilled Nursing Care	0	0	0	512,703	43,964	0	2.00
3.00 Physical Therapy	0	0	0	237,982	20,407	0	3.00
4.00 Occupational Therapy	0	0	0	25,743	2,207	0	4.00
5.00 Speech Pathology	0	0	0	5,056	434	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	30,882	2,648	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)	611	0	8,870	1,173,659	100,641	33,462	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: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet H-2 Part I Date/Time Prepared: 3/31/2021 12:34 pm
		HHA CCN: 15-7055	Home Health Agency I	PPS

Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	10,474	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	10,474	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	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PHARMACY RESIDENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	15.00	16.00	17.00	23.00	24.00	25.00	
1.00	Administrative and General	0	6,052	314	0	442,576	1.00
2.00	Skilled Nursing Care	0	0	0	0	556,667	2.00
3.00	Physical Therapy	0	0	0	0	258,389	3.00
4.00	Occupational Therapy	0	0	0	0	27,950	4.00
5.00	Speech Pathology	0	0	0	0	5,490	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	33,530	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	6,052	314	0	1,324,602	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0086	Period: From 01/01/2020	Worksheet H-2 Part I
		HHA CCN: 15-7055	To 10/31/2020	Date/Time Prepared: 3/31/2021 12:34 pm
			Home Health Agency I	PPS

Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		26.00	27.00	28.00		
1.00	Administrative and General	442,576				1.00
2.00	Skilled Nursing Care	556,667	279,320	835,987		2.00
3.00	Physical Therapy	258,389	129,652	388,041		3.00
4.00	Occupational Therapy	27,950	14,025	41,975		4.00
5.00	Speech Pathology	5,490	2,755	8,245		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	33,530	16,824	50,354		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,324,602	442,576	1,324,602		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.		0.501772			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: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2020 To 10/31/2020	Worksheet H-2 Part II Date/Time Prepared: 3/31/2021 12:34 pm
		Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	1,485	1,485	675,891	6	41	16,509	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)	1,485	1,485	675,891	6	41	16,509	20.00
21.00 Total cost to be allocated	15,085	6,129	199,539	965	130,094	611	21.00
22.00 Unit cost multiplier	10.158249	4.127273	0.295224	160.833333	3,173.024390	0.037010	22.00
Cost Center Description	ADMINISTRATIVE (ADMISSIONS)	CASHIERING/AC COUNTS RECEIVABLE (ADJUSTED CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	5.04	5.05	5A.06	5.06	7.00	8.00	
1.00 Administrative and General	0	927,357	0	361,293	1,485	0	1.00
2.00 Skilled Nursing Care	0	0	0	512,703	0	0	2.00
3.00 Physical Therapy	0	0	0	237,982	0	0	3.00
4.00 Occupational Therapy	0	0	0	25,743	0	0	4.00
5.00 Speech Pathology	0	0	0	5,056	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	30,882	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	927,357	0	1,173,659	1,485	0	20.00
21.00 Total cost to be allocated	0	8,870	0	100,641	33,462	0	21.00
22.00 Unit cost multiplier	0.000000	0.009565	0	0.085750	22.533333	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2020 To 10/31/2020	Worksheet H-2 Part II Date/Time Prepared: 3/31/2021 12:34 pm
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Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (GROSS HOURS)	CENTRAL SERVICE & SUPPLY (100%)	PHARMACY (100%)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	1,485	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	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,485	0	0	0	0	0	20.00
21.00	Total cost to be allocated	10,474	0	0	0	0	0	21.00
22.00	Unit cost multiplier	7.053199	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		MEDICAL RECORDS & LIBRARY (ADJUSTED CHARGES)	SOCIAL SERVICE (TIME SPENT)	PHARMACY RESIDENCY (ASSIGNED TIME)				
		16.00	17.00	23.00				
1.00	Administrative and General	927,357	3	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Tel emedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	927,357	3	0				20.00
21.00	Total cost to be allocated	6,052	314	0				21.00
22.00	Unit cost multiplier	0.006526	104.666667	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet H-3 Part I Date/Time Prepared: 3/31/2021 12:34 pm
		HHA CCN: 15-7055		

Title XVIII			Home Health Agency I	PPS
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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	835,987		835,987	2,351	355.59	1.00
2.00	Physical Therapy	3.00	388,041	0	388,041	1,902	204.02	2.00
3.00	Occupational Therapy	4.00	41,975	0	41,975	429	97.84	3.00
4.00	Speech Pathology	5.00	8,245	0	8,245	46	179.24	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	50,354		50,354	138	364.88	6.00
7.00	Total (sum of lines 1-6)		1,324,602	0	1,324,602	4,866		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits			
			Part A	Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	1,176		8.00
8.01	Skilled Nursing Care		99915	0	200		8.01
9.00	Physical Therapy		17140	0	804		9.00
9.01	Physical Therapy		99915	0	137		9.01
10.00	Occupational Therapy		17140	0	183		10.00
10.01	Occupational Therapy		99915	0	30		10.01
11.00	Speech Pathology		17140	0	16		11.00
11.01	Speech Pathology		99915	0	0		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	104		13.00
13.01	Home Health Aide		99915	0	23		13.01
14.00	Total (sum of lines 8-13)			0	2,673		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	14,400	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

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	1,376		0	489,292	1.00
2.00	Physical Therapy	0	941		0	191,983	2.00
3.00	Occupational Therapy	0	213		0	20,840	3.00
4.00	Speech Pathology	0	16		0	2,868	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	127		0	46,340	6.00
7.00	Total (sum of lines 1-6)	0	2,673		0	751,323	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0086	Period: From 01/01/2020	Worksheet H-3
				HHA CCN: 15-7055	To 10/31/2020	Part I
				Title XVIII	Home Health Agency I	Date/Time Prepared: 3/31/2021 12:34 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 A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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	14,400	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	16.00

Cost Center Description		Total Program Cost (sum of col.s. 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	489,292	1.00
2.00	Physical Therapy	191,983	2.00
3.00	Occupational Therapy	20,840	3.00
4.00	Speech Pathology	2,868	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	46,340	6.00
7.00	Total (sum of lines 1-6)	751,323	7.00

Cost Center Description		12.00
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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: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2020 To 10/31/2020	Worksheet H-3 Part II Date/Time Prepared: 3/31/2021 12:34 pm
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.668339	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.385351	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.584700	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.512591	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.476941	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2020 To 10/31/2020	Worksheet H-4 Part I-II Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	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
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			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	483,217	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	19,852	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,797	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,243	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	6,381	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	525,490	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	525,490	24.00
25.00	Coinurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	525,490	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	525,490	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	525,490	31.00
31.01	Sequestration adjustment (see instructions)	0	4,860	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	520,630	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: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2020 To 10/31/2020	Worksheet H-5 Date/Time Prepared: 3/31/2021 12:34 pm PPS
		Home Health Agency I	

		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		520,630	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		520,630	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		520,630	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: 15-0086

Period: From 01/01/2020

Worksheet 0

Hospice CCN: 15-1531

To 10/31/2020

Date/Time Prepared: 3/31/2021 12:34 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
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	8,543	731	9,274	-1,574	7,700
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	1,361	0	1,361	0	1,361
12.00	STAFF TRANSPORTATION*	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	0	0	0	0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	500	500	0	500
16.00	OTHER GENERAL SERVICE*	0	35,297	35,297	0	35,297
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	0	0	0	0
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	2,906	0	2,906	0	2,906
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0
34.00	SPIRITUAL COUNSELING**	89	0	89	0	89
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	118	0	118	0	118
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	1,574	1,574	0	1,574
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	280	280	0	280
100.00	TOTAL	13,017	38,382	51,399	-1,574	49,825

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0

Hospice CCN: 15-1531

To 10/31/2020

Date/Time Prepared: 3/31/2021 12:34 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		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*	-280	7,420	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	1,361	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	500	15.00
16.00	OTHER GENERAL SERVICE*	0	35,297	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	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	2,906	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	0	33.00
34.00	SPIRITUAL COUNSELING**	0	89	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	118	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	1,574	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	280	71.00
100.00	TOTAL	-280	49,545	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0086 Hospice CCN: 15-1531	Period: From 01/01/2020 To 10/31/2020	Worksheet 0-2 Date/Time Prepared: 3/31/2021 12:34 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00						25.00
26.00						26.00
27.00						27.00
28.00	2,244		2,244		2,244	28.00
29.00						29.00
30.00						30.00
31.00						31.00
32.00						32.00
33.00						33.00
34.00	69		69		69	34.00
35.00						35.00
36.00						36.00
37.00	91		91		91	37.00
38.00						38.00
39.00						39.00
40.00						40.00
41.00						41.00
42.00		1,344	1,344		1,344	42.00
42.50						42.50
43.00						43.00
44.00						44.00
45.00						45.00
46.00						46.00
100.00	2,404	1,344	3,748		3,748	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS		TOTAL (col. 5 ± col. 6)		
	6.00		7.00		
DI RECT PATIENT CARE SERVICE COST CENTERS					
25.00					25.00
26.00					26.00
27.00					27.00
28.00			2,244		28.00
29.00					29.00
30.00					30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00			69		34.00
35.00					35.00
36.00					36.00
37.00			91		37.00
38.00					38.00
39.00					39.00
40.00					40.00
41.00					41.00
42.00			1,344		42.00
42.50					42.50
43.00					43.00
44.00					44.00
45.00					45.00
46.00					46.00
100.00			3,748		100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

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

Provider CCN: 15-0086

Period:
From 01/01/2020
To 10/31/2020

Worksheet 0-4

Hospice CCN: 15-1531

Date/Time Prepared:
3/31/2021 12:34 pm

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	662	0	662	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	20	0	20	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	27	0	27	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	230	230	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	709	230	939	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	0	28.00
29.00	LPN/LVN	662	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	20	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	27	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	230	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	939	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-5

Hospice CCN: 15-1531

To 10/31/2020

Date/Time Prepared: 3/31/2021 12:34 pm

Descriptions		Hospice I		
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of col s. 1 + 2)
		1.00	2.00	3.00
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	3,200	3,200 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,300	1,300 2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	3,843	3,843 3.00
4.00	ADMINISTRATIVE & GENERAL	7,420	5,366	12,786 4.00
5.00	PLANT OPERATION & MAINTENANCE	0	7,098	7,098 5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0 6.00
7.00	HOUSEKEEPING	0	2,222	2,222 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	1,361	202	1,563 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	500	0	500 15.00
16.00	OTHER GENERAL SERVICE	35,297	0	35,297 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	9,953	9,953 17.00
LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	3,748	0	3,748 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	939	0	939 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	0	0	0 70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	280	0	280 71.00
99.00	NEGATIVE COST CENTER	0	0	0 99.00
100.00	TOTAL	49,545	33,184	82,729 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1531

To 10/31/2020

Part I
Date/Time Prepared:
3/31/2021 12:34 pm

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 & FIX	3,200	3,200			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,300		1,300		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	3,843	0	0	3,843	3.00
4.00	ADMINISTRATIVE & GENERAL	12,786	0	0	0	12,786 4.00
5.00	PLANT OPERATION & MAINTENANCE	7,098	0	0	0	7,098 5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0 6.00
7.00	HOUSEKEEPING	2,222	0	0	0	2,222 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	1,563	0	0	0	1,563 11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0 12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0 13.00
14.00	PHARMACY	0	0	0	0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	500	0	0	0	500 15.00
16.00	OTHER GENERAL SERVICE	35,297	0	0	0	35,297 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		9,953 17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	3,748			2,968	6,716 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	939	3,200	1,300	875	6,314 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)	280	0	0	0	280 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	82,729	3,200	1,300	3,843	82,729 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet 0-6 Part I
		Hospice CCN: 15-1531		Date/Time Prepared: 3/31/2021 12:34 pm

Descriptions	Hospice I					
	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	12,786				4.00
5.00	PLANT OPERATION & MAINTENANCE	1,298	8,396			5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0		6.00
7.00	HOUSEKEEPING	406	0		2,628	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	286	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	91	0		0	15.00
16.00	OTHER GENERAL SERVICE	6,453	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	1,819	0		0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	1,228				51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,154	8,396	0	2,628	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	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)	51	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	12,786	8,396	0	2,628	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet 0-6 Part I Date/Time Prepared: 3/31/2021 12:34 pm
		Hospice CCN: 15-1531		

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	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		1,849		11.00
12.00	STAFF TRANSPORTATION	0			0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	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
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	1,579	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	270	0	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					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	0	0	1,849	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1531

To 10/31/2020

Part I
Date/Time Prepared:
3/31/2021 12:34 pm

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00	0	591				15.00
16.00	0		41,750			16.00
17.00				11,772		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	0	505	35,661		45,689	51.00
52.00	0	0	0	0	0	52.00
53.00	0	86	6,089	11,772	36,709	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	331	71.00
99.00	0	0	0	0	0	99.00
100.00	0	591	41,750	11,772	82,729	100.00

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

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1531

To 10/31/2020

Part II
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Descriptions		Hospice I					
		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	100					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		100				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	13,017			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-12,786	69,943	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	7,098	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	2,222	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	1,563	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	500	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	35,297	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	9,953	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			10,052	0	6,716	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	100	100	2,965	0	6,314	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	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	280	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	3,200	1,300	3,843		12,786	100.00
101.00	UNIT COST MULTIPLIER	32.000000	13.000000	0.295229		0.182806	101.00

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

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1531

To 10/31/2020

Part II
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Descriptions		Hospice I					
		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	100					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		100			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		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 RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	100	0	100	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. 0-6, Part I)	8,396	0	2,628	0	0	100.00
101.00	UNIT COST MULTIPLIER	83.960000	0.000000	26.280000	0.000000	0.000000	101.00

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

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1531

To 10/31/2020

Part II
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Descriptions		Hospice I					
		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	48					10.00
11.00	MEDICAL RECORDS		48				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			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	41	41	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7	7	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	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	0	0	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. 0-6, Part I)	0	1,849	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	38.520833	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0086

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1531

To 10/31/2020

Part II
Date/Time Prepared:
3/31/2021 12:34 pm

Cost Center Descriptions		Hospice I			
		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	
GENERAL SERVICE COST CENTERS		15.00	16.00	17.00	
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	48			15.00
16.00	OTHER GENERAL SERVICE		48		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			7	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	41	41		51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7	7	7	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		0		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. 0-6, Part I)	591	41,750	11,772	100.00
101.00	UNIT COST MULTIPLIER	12.312500	869.791667	1,681.714286	101.00

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

Provider CCN: 15-0086

Period: From 01/01/2020 To 10/31/2020

Worksheet 0-7

Hospice CCN: 15-1531

Date/Time Prepared: 3/31/2021 12:34 pm

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	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.668339	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.385351	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.584700	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.476941	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.231215	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.512591	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.244791	0	0	0	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)		Shared Service Costs by LOC			
		HGIP		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
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
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	0	0	0	0	0	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: 15-0086

Period: From 01/01/2020

Worksheet 0-8

Hospice CCN: 15-1531

To 10/31/2020

Date/Time Prepared: 3/31/2021 12:34 pm

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)			
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			45,689
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			41
8.00	Total average cost per diem (line 6 divided by line 7)			1,114.37
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	41	0	
10.00	Program cost (line 8 times line 9)	45,689	0	
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			0
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0
13.00	Total average cost per diem (line 11 divided by line 12)			0.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0	
15.00	Program cost (line 13 times line 14)	0	0	
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			36,709
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			7
18.00	Total average cost per diem (line 16 divided by line 17)			5,244.14
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	7	0	
20.00	Program cost (line 18 times line 19)	36,709	0	
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			82,398
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			48
23.00	Average cost per diem (line 21 divided by line 22)			1,716.63

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet L Parts I-III Date/Time Prepared: 3/31/2021 12:34 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		662,815	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		77,744	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		26.58	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		740,559	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00