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: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 3:31 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/2/2021 Time: 3:31 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAIRBANKS (15-0179) for the cost reporting period beginning 07/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) HOLLY MILLARD
Officer or Administrator of Provider(s)

NETWORK SVP OF FINANCE
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	155,781	0	0	189	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	155,781	0	0	189	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:31 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8102 CLEARVISTA	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46256	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FAIRBANKS	150179	26900	1	01/10/2012	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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

		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.	283	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:31 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 3:31 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 3:31 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:31 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	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
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:31 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	82,128	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 3:31 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSON PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1500 N RITTER	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46219-3095	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 8/2/2021 3:31 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/25/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/01/2021	Y	07/01/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:31 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:31 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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 8/2/2021 3:31 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	86	15,824	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)		86	15,824	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	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)		86	15,824	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		86				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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 3:31 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	259	283	6,274			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	259	283	6,274			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			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)	259	283	6,274	0.00	101.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	101.85	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 3:31 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	56	63	1,050	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	56	63	1,050	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 3:31 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	6,763,255	-23,639	6,739,616	211,842.00	31.81	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		173,558	0	173,558	1,216.00	142.73	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		435,824	1,244	437,068	18,372.00	23.79	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		135	0	135	3.00	45.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		929,988	0	929,988	19,475.00	47.75	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,400,656	0	1,400,656			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		123,584	0	123,584			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		11,742	0	11,742			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		208,691	0	208,691			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 8/2/2021 3:31 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	4.00	90,869	0	90,869	3,361.00	27.04	26.00
27.00	Administrative & General	5.00	1,493,109	-7,143	1,485,966	30,426.00	48.84	27.00
28.00	Administrative & General under contract (see inst.)		140,596	0	140,596	739.00	190.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	147,924	0	147,924	6,156.00	24.03	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	217,253	0	217,253	12,124.00	17.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	133,557	-35,774	97,783	4,696.00	20.82	34.00
35.00	Dietary under contract (see instructions)		149,975	0	149,975	7,316.00	20.50	35.00
36.00	Cafeteria	11.00	0	35,774	35,774	1,718.00	20.82	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	122,007	0	122,007	5,176.00	23.57	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 8/2/2021 3:31 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet 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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		6,880,268	-23,639	6,856,629	218,681.00	31.35	1.00
2.00	Excluded area salaries (see instructions)		435,824	1,244	437,068	18,372.00	23.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)		6,444,444	-24,883	6,419,561	200,309.00	32.05	3.00
4.00	Subtotal other wages & related costs (see inst.)		930,123	0	930,123	19,478.00	47.75	4.00
5.00	Subtotal wage-related costs (see inst.)		1,609,347	0	1,609,347	0.00	25.07	5.00
6.00	Total (sum of lines 3 thru 5)		8,983,914	-24,883	8,959,031	219,787.00	40.76	6.00
7.00	Total overhead cost (see instructions)		2,495,290	-7,143	2,488,147	71,712.00	34.70	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 3:31 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	33,402	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)	482,290	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	82,487	9.00
10.00	Dental, Hearing and Vision Plan	4,701	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	177,550	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)	55,403	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	4,281	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	459,040	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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	236,828	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,535,982	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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 8/2/2021 3:31 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	135	1,535,982	1.00
2.00	Hospital	135	1,412,398	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			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	123,584	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 8/2/2021 3:31 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)	0.577970	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	183,228	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	1,367,653	6.00
7.00	Medicaid cost (line 1 times line 6)	790,462	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)	607,234	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)	607,234	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)	176,099	152,127	328,226	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	101,780	152,127	253,907	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)	101,780	152,127	253,907	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)	828,036	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	0	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	0	27.01
28.00	Non-Medicare bad debt expense (see instructions)	828,036	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	478,580	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	732,487	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,339,721	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	512,448	512,448	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	90,869	2,253	93,122	0	93,122	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,493,109	3,259,056	4,752,165	-306,917	4,445,248	5.00
7.00	00700	OPERATION OF PLANT	147,924	368,458	516,382	-17,290	499,092	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	217,253	101,244	318,497	-3,176	315,321	9.00
10.00	01000	DIETARY	133,557	356,616	490,173	-135,831	354,342	10.00
11.00	01100	CAFETERIA	0	0	0	129,636	129,636	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,007	41,009	163,016	0	163,016	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,309,229	1,692,443	5,001,672	-3,676	4,997,996	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,905	1,905	0	1,905	54.00
60.00	06000	LABORATORY	0	75,956	75,956	0	75,956	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	158,854	158,854	-2,293	156,561	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	594,295	802,963	1,397,258	-129,633	1,267,625	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	219,188	212,371	431,559	0	431,559	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,327,431	7,073,128	13,400,559	43,268	13,443,827	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,361	28,361	0	28,361	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	411,946	570,473	982,419	-30,687	951,732	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	26,300	120,625	146,925	-12,581	134,344	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	-2,422	-777	-3,199	0	-3,199	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,763,255	7,791,810	14,555,065	0	14,555,065	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	512,448		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	375,949	469,071		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,265,419	2,179,829		5.00
7.00	00700	OPERATION OF PLANT	0	499,092		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	315,321		9.00
10.00	01000	DIETARY	0	354,342		10.00
11.00	01100	CAFETERIA	-31,601	98,035		11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,933	160,083		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,027,059	3,970,937		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,905		54.00
60.00	06000	LABORATORY	-387,232	-311,276		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	156,561		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-745,688	521,937		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	-155,887	275,672		93.99
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,239,870	9,203,957		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,361		190.00
194.00	07950	EAP	0	0		194.00
194.01	07951	FAIRBANKS INSTITUTE	0	951,732		194.01
194.02	07952	OTHER NON-REIM	0	0		194.02
194.03	07953	MARKETING	0	134,344		194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	3,199	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,236,671	10,318,394		200.00

RECLASSIFICATIONS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:31 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Cafeteria					
1.00	CAFETERIA	11.00	35,774	93,862		1.00
	TOTALS		35,774	93,862		
	B - Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	352,529		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	352,529		
	C - Other Capital Rental					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159,919		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	159,919		
	D - STD BENEFIT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,143		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,887		2.00
3.00	CLINIC	90.00	0	6,853		3.00
4.00	FAIRBANKS INSTITUTE	194.01	0	1,178		4.00
	TOTALS		0	26,061		
	E - MOVE NEG SAL TO OTH TO ELIM HFS EDIT					
1.00	RECOVERY SCHOOL/(HOPE ACADEMY)	194.04	2,422	0		1.00
	TOTALS		2,422	0		
500.00	Grand Total: Increases		38,196	632,371		500.00

RECLASSIFICATIONS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:31 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	35,774	93,862	0		1.00
	TOTALS		35,774	93,862			
	B - Depreciation						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	271,101	9		1.00
2.00	OPERATION OF PLANT	7.00	0	16,788	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,600	0		3.00
4.00	DIETARY	10.00	0	6,027	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,415	0		5.00
6.00	CLINIC	90.00	0	10,330	0		6.00
7.00	FAIRBANKS INSTITUTE	194.01	0	30,687	0		7.00
8.00	MARKETING	194.03	0	12,581	0		8.00
	TOTALS		0	352,529			
	C - Other Capital Rental						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	35,816	10		1.00
2.00	OPERATION OF PLANT	7.00	0	502	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,576	0		3.00
4.00	DIETARY	10.00	0	168	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	261	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,293	0		6.00
7.00	CLINIC	90.00	0	119,303	0		7.00
	TOTALS		0	159,919			
	D - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	7,143	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	10,887	0	0		2.00
3.00	CLINIC	90.00	6,853	0	0		3.00
4.00	FAIRBANKS INSTITUTE	194.01	1,178	0	0		4.00
	TOTALS		26,061	0			
	E - MOVE NEG SAL TO OTH TO ELIM HFS EDIT						
1.00	RECOVERY SCHOOL/(HOPE ACADEMY)	194.04	0	2,422	0		1.00
	TOTALS		0	2,422			
500.00	Grand Total: Decreases		61,835	608,732			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 8/2/2021 3:31 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	230,000	0	0	0	80,000	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,768,941	308,636	0	308,636	651,499	3.00
4.00	Building Improvements	0	0	0	0	-382,577	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	913,585	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,912,526	308,636	0	308,636	348,922	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,912,526	308,636	0	308,636	348,922	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	150,000	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	15,426,078	0	3.00
4.00	Building Improvements	382,577	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	913,585	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,872,240	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,872,240	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 8/2/2021 3:31 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 8/2/2021 3:31 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,958,654	0	15,958,654	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	15,958,654	0	15,958,654	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	352,529	159,919	1.00
3.00	Total (sum of lines 1-2)	0	0	0	352,529	159,919	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	512,448	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	512,448	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 3:31 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-398,421			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	-525,394			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 3:31 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	REMOVE NEGATIVE NRCC EXPENSE	A	3,199	RECOVERY SCHOOL/(HOPE ACADEMY)	194.04	0	33.00
33.01	Cafeteria & Coffee Svcs Revenue	B	-31,601	CAFETERIA	11.00	0	33.01
33.02	Misc Revenue	B	3,030	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	Misc Revenue	B	-2,933	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	Misc Revenue	B	-5,445	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	Misc Revenue	B	-50,807	CLINIC	90.00	0	33.05
33.06	Assisted Living Offset	A	-401,214	CLINIC	90.00	0	33.06
33.07	Interest Income	B	-3,017	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	Bad Debt	A	-1,356,920	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	Bad Debt	A	-973,022	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	Bad Debt	A	-269,336	CLINIC	90.00	0	33.10
33.11	Bad Debt	A	-155,887	PARTIAL HOSPITALIZATION PROGRAM	93.99	0	33.11
33.12	Sponsorship	A	-386	CLINIC	90.00	0	33.12
33.13	APP	A	-53,326	ADULTS & PEDIATRICS	30.00	0	33.13
33.14	APP	A	-15,191	CLINIC	90.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,236,671				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 3:31 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	375,949	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	170,377	1,076,454	2.00
3.00	30.00	ADULTS & PEDIATRICS	HOME OFFICE	4,734	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			551,060	1,076,454	5.00

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

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

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

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

6.00	C	CHNW	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 8/2/2021 3:31 pm

		Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		375,949	0		1.00
2.00		-906,077	0		2.00
3.00		4,734	0		3.00
4.00		0	0		4.00
5.00		-525,394			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 8/2/2021 3:31 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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	2,435	2,435	0	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	387,232	387,232	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	8,754	8,754	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			398,421	398,421	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	2,435		1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	387,232		2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	8,754		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	398,421		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	512,448	512,448				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	469,071	9,408	478,479			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,179,829	68,351	106,938	2,355,118	2,355,118	5.00
7.00	00700	OPERATION OF PLANT	499,092	16,817	10,645	526,554	149,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	315,321	3,481	15,635	334,437	95,188	9.00
10.00	01000	DIETARY	354,342	70,912	7,037	432,291	123,040	10.00
11.00	01100	CAFETERIA	98,035	0	2,574	100,609	28,636	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,083	2,260	8,780	171,123	48,705	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,970,937	215,797	237,367	4,424,101	1,259,195	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,905	0	0	1,905	542	54.00
60.00	06000	LABORATORY	-311,276	0	0	-311,276	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,561	0	0	156,561	44,561	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	521,937	38,689	42,275	602,901	171,599	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	275,672	13,168	15,774	304,614	86,700	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,203,957	438,883	447,025	9,098,938	2,008,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,361	0	0	28,361	8,072	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	951,732	61,530	29,561	1,042,823	296,810	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	134,344	12,035	1,893	148,272	42,201	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	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)	10,318,394	512,448	478,479	10,318,394	2,355,118	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	676,423					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	5,635	0	435,260			9.00
10.00	01000	DIETARY	114,787	0	74,483	744,601		10.00
11.00	01100	CAFETERIA	0	0	0	0	129,245	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,659	0	2,374	0	4,916	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	349,316	0	226,664	744,601	95,383	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,628	0	40,638	0	20,282	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	21,315	0	13,831	0	7,631	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	557,340	0	357,990	744,601	128,212	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	99,601	0	64,629	0	0	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	19,482	0	12,641	0	1,033	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	676,423	0	435,260	744,601	129,245	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	230,777					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	169,797	7,269,057	0	7,269,057		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,447	0	2,447		54.00
60.00	06000	LABORATORY	0	-311,276	0	-311,276		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	201,122	0	201,122		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,879	933,927	0	933,927		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	25,101	459,192	0	459,192		93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	230,777	8,554,469	0	8,554,469		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,433	0	36,433		190.00
194.00	07950	EAP	0	0	0	0		194.00
194.01	07951	FAIRBANKS INSTITUTE	0	1,503,863	0	1,503,863		194.01
194.02	07952	OTHER NON-REIM	0	0	0	0		194.02
194.03	07953	MARKETING	0	223,629	0	223,629		194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	230,777	10,318,394	0	10,318,394		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,408	9,408	9,408		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	68,351	68,351	2,103	70,454	5.00
7.00	00700	OPERATION OF PLANT	0	16,817	16,817	209	4,484	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	3,481	3,481	307	2,848	9.00
10.00	01000	DIETARY	0	70,912	70,912	138	3,681	10.00
11.00	01100	CAFETERIA	0	0	0	51	857	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,260	2,260	173	1,457	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	215,797	215,797	4,668	37,666	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	16	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,333	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	38,689	38,689	831	5,134	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	13,168	13,168	310	2,594	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	438,883	438,883	8,790	60,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	241	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	61,530	61,530	581	8,880	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	12,035	12,035	37	1,263	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	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	512,448	512,448	9,408	70,454	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	21,510					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	179	0	6,815			9.00
10.00	01000	DIETARY	3,650	0	1,166	79,547		10.00
11.00	01100	CAFETERIA	0	0	0	0	908	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116	0	37	0	35	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,108	0	3,549	79,547	670	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,992	0	636	0	142	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	678	0	217	0	54	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,723	0	5,605	79,547	901	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	3,167	0	1,012	0	0	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	620	0	198	0	7	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,510	0	6,815	79,547	908	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,078					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,000	356,005	0	356,005		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16	0	16		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,333	0	1,333		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	634	48,058	0	48,058		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	444	17,465	0	17,465		93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,078	422,877	0	422,877		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	241	0	241		190.00
194.00	07950	EAP	0	0	0	0		194.00
194.01	07951	FAIRBANKS INSTITUTE	0	75,170	0	75,170		194.01
194.02	07952	OTHER NON-REIM	0	0	0	0		194.02
194.03	07953	MARKETING	0	14,160	0	14,160		194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	0	0		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,078	512,448	0	512,448		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	115,856					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,127	6,648,747				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,453	1,485,966	-2,355,118	8,274,552		5.00
7.00	00700	OPERATION OF PLANT	3,802	147,924	0	526,554	94,474	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	787	217,253	0	334,437	787	9.00
10.00	01000	DIETARY	16,032	97,783	0	432,291	16,032	10.00
11.00	01100	CAFETERIA	0	35,774	0	100,609	0	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	511	122,007	0	171,123	511	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,788	3,298,342	0	4,424,101	48,788	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,905	0	54.00
60.00	06000	LABORATORY	0	0	311,276	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	156,561	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,747	587,442	0	602,901	8,747	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,977	219,188	0	304,614	2,977	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,224	6,211,679	-2,043,842	7,055,096	77,842	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	28,361	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	13,911	410,768	0	1,042,823	13,911	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	2,721	26,300	0	148,272	2,721	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	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)	512,448	478,479		2,355,118	676,423	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.423146	0.071965		0.284622	7.159885	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		9,408		70,454	21,510	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001415		0.008515	0.227682	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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:31 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (100% ALLOCATION)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			8.00	9.00	10.00	11.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0					8.00
9.00	00900	HOUSEKEEPING	0	93,687				9.00
10.00	01000	DIETARY	0	16,032	12,579			10.00
11.00	01100	CAFETERIA	0	0	0	136,076		11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	511	0	5,176	15,339,467	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	48,788	12,579	100,424	11,286,279	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,747	0	21,354	2,384,776	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	2,977	0	8,034	1,668,412	93.99
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	77,055	12,579	134,988	15,339,467	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	EAP	0	0	0	0	0	194.00
194.01	07951	FAIRBANKS INSTITUTE	0	13,911	0	0	0	194.01
194.02	07952	OTHER NON-REIM	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	2,721	0	1,088	0	194.03
194.04	07954	RECOVERY SCHOOL/(HOPE ACADEMY)	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)	0	435,260	744,601	129,245	230,777	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4.645895	59.193974	0.949800	0.015045	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,815	79,547	908	4,078	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.072742	6.323794	0.006673	0.000266	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,269,057		7,269,057	0	7,269,057	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,447		2,447	0	2,447	54.00
60.00	06000	LABORATORY	0		0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,122		201,122	0	201,122	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	933,927		933,927	0	933,927	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	459,192		459,192	0	459,192	93.99
200.00		Subtotal (see instructions)	8,865,745	0	8,865,745	0	8,865,745	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	8,865,745	0	8,865,745	0	8,865,745	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,286,279		11,286,279			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,384,776	2,384,776	0.391620	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	1,668,412	1,668,412	0.275227	0.000000	93.99
200.00		Subtotal (see instructions)	11,286,279	4,053,188	15,339,467			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,286,279	4,053,188	15,339,467			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.391620		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.275227		93.99
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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,269,057		7,269,057	0	7,269,057	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,447		2,447	0	2,447	54.00
60.00	06000	LABORATORY	0		0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,122		201,122	0	201,122	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	933,927		933,927	0	933,927	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	459,192		459,192	0	459,192	93.99
200.00		Subtotal (see instructions)	8,865,745	0	8,865,745	0	8,865,745	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	8,865,745	0	8,865,745	0	8,865,745	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,286,279		11,286,279			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,384,776	2,384,776	0.391620	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	1,668,412	1,668,412	0.275227	0.000000	93.99
200.00		Subtotal (see instructions)	11,286,279	4,053,188	15,339,467			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,286,279	4,053,188	15,339,467			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:31 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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	356,005	0	356,005	6,274	56.74	30.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
200.00	Total (lines 30 through 199)	356,005		356,005	6,274		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	259	14,696		30.00
33.00	BURN INTENSIVE CARE UNIT	0	0		33.00
200.00	Total (lines 30 through 199)	259	14,696		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	16	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	0	0	0.000000	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333	0	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,058	2,384,776	0.020152	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	17,465	1,668,412	0.010468	0	0	93.99
200.00		Total (lines 50 through 199)	66,872	4,053,188		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 3:31 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
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,274	0.00	259	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00
200.00		Total (lines 30 through 199)		0	6,274		259	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,384,776	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	1,668,412	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	4,053,188		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	7,851	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	79,348	0	93.99
200.00		Total (lines 50 through 199)		0	0	87,199	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.391620	7,851	0	0	3,075	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.275227	79,348	0	0	21,839	93.99
200.00		Subtotal (see instructions)		87,199	0	0	24,914	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		87,199	0	0	24,914	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.391620	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.275227	0	687	0	0	93.99
200.00		Subtotal (see instructions)		0	687	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	687	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	189	0	93.99
200.00		Subtotal (see instructions)	189	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	189	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,274	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)	6,274	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)	259	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)	7,269,057	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)	7,269,057	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)	7,269,057	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)	1,158.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	300,077	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)	300,077	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	300,077	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)	14,696	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	14,696	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	285,381	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	356,005	7,269,057	0.048975	0	0	90.00
91.00	Nursing School cost	0	7,269,057	0.000000	0	0	91.00
92.00	Allied health cost	0	7,269,057	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,269,057	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:31 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,274	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)	6,274	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)	283	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)	7,269,057	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)	7,269,057	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)	7,269,057	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)	1,158.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	327,884	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)	327,884	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:31 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	327,884	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:31 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	356,005	7,269,057	0.048975	0	0	90.00
91.00	Nursing School cost	0	7,269,057	0.000000	0	0	91.00
92.00	Allied health cost	0	7,269,057	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,269,057	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 3:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		553,546		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.391620	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.275227	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 3:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		553,546		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.391620	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.275227	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:31 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)	256,285	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	173,046	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)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	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)	86.00	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)	14.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)	4.51	31.00
32.00	Sum of lines 30 and 31	19.18	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.22	33.00
34.00	Disproportionate share adjustment (see instructions)	5,603	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:31 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)	0.000069353	0.000052888	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	579,135	438,440	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	145,575	110,511	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	256,086		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 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	691,020		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)	691,020	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	34,666	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 intructions)	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)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	725,686	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	725,686	61.00
62.00	Deductibles billed to program beneficiaries	60,544	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	665,142	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)		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)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet E Part A Date/Time Prepared: 8/2/2021 3:31 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)	0	0	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)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		665,142	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		509,361	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		155,781	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		31,262	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	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
	Comparision 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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	24,914	2.00
3.00	OPPS payments	25,465	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	25,465	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)	5,112	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)	20,353	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)	20,353	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	20,353	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	20,353	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	20,353	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	20,353	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 8/2/2021 3:31 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		509,361		20,353	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		509,361		20,353	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		155,781		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		665,142		20,353	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: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 3:31 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: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 3:31 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	327,884		1.00
2.00	Medical and other services		189	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	327,884	189	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)	327,884	189	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	687	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)	0	687	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)	0	687	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	498	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	327,884	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)	0	189	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)	0	189	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	327,884	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	189	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	189	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	189	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)	0	189	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	189	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: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 8/2/2021 3:31 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	1,916,495	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	8,894,214	0	0	0	4.00
5.00	Other receivable	-6,579,474	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	354,898	0	0	0	6.00
7.00	Inventory	14,014	0	0	0	7.00
8.00	Prepaid expenses	24,605	0	0	0	8.00
9.00	Other current assets	62,029	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)	4,686,781	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	150,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	15,426,077	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	382,577	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	794,862	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	58,723	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-727,016	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	60,000	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,145,223	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	-6,992,796	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-6,992,796	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,839,208	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	279,164	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	100,489	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	379,653	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,713	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,713	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	393,366	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,445,842				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)	13,445,842	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,839,208	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 8/2/2021 3:31 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		17,681,974		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,236,134				2.00
3.00	Total (sum of line 1 and line 2)		13,445,840		0		3.00
4.00	ROUNDING	2		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,445,842		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)		13,445,842		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/2/2021 3:31 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,285,913		11,285,913	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,285,913		11,285,913	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,285,913		11,285,913	17.00
18.00	Ancillary services	0	5,404,360	5,404,360	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,285,913	5,404,360	16,690,273	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,555,065		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)		14,555,065		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0179 | Period: From 07/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 8/2/2021 3:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	16,690,273	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,797,964	2.00
3.00	Net patient revenues (line 1 minus line 2)	9,892,309	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,555,065	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,662,756	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	119,129	6.00
7.00	Income from investments	3,017	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	43,192	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	2,933	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	23,462	20.00
21.00	Rental of vending machines	1,912	21.00
22.00	Rental of hospital space	192,745	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	40,232	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	426,622	25.00
26.00	Total (line 5 plus line 25)	-4,236,134	26.00
27.00	INCOME TAX	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)	-4,236,134	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 3:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	34,666	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	34.10	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)	34,666	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