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: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/29/2021 2:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/29/2021 Time: 2:33 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 GOOD SAMARITAN HOSPITAL (15-0042) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) THOM COOK
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	854,381	222,911	0	-627,042	1.00
2.00	Subprovider - IPF	0	112,819	65		167,674	2.00
3.00	Subprovider - IRF	0	40,781	0		-53,787	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	1,007,981	222,976	0	-513,155	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 2:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 520 SOUTH 7TH STREET	PO Box:			1.00
2.00	City: VINCENNES	State: IN	Zip Code: 47591	County: KNOX	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	GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	O	4.00
5.00	Subprovider - IRF	GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	O	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	GOOD SAMARITAN HOME CENTER	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	9		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	486	996	321	176	1,217	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 2:33 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.	21	115	0	63	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/01/2020	12/31/2020	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)	Y	Y	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.	Y	Y		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.	N			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.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 2:33 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

		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	4.27	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)	INTERNAL MEDICINE	1400	0.00	6.46	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.	Y			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	Y	1	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

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

		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.	Y			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:	438,140	0	0	118.01

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

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

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

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

		1.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 2:33 pm

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

		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)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/22/2021	Y	04/22/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/29/2021 2:33 pm

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 2:33 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	69	25,254	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)		69	25,254	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,980	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,234	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,320		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,150		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		144				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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 2:33 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)	6,321	363	12,046			1.00
2.00	HMO and other (see instructions)	2,175	2,667				2.00
3.00	HMO IPF Subprovider	281	1,782				3.00
4.00	HMO IRF Subprovider	483	178				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)	6,321	363	12,046			7.00
8.00	INTENSIVE CARE UNIT	3,648	62	6,301			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		56	930			13.00
14.00	Total (see instructions)	9,969	481	19,277	8.14	1,435.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,379	394	4,639	2.58	32.36	16.00
17.00	SUBPROVIDER - IRF	5,377	21	6,447	0.00	29.88	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	6.74	24.00
24.10	HOSPICE (non-distinct part)			388			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)				10.72	1,504.73	27.00
28.00	Observation Bed Days		436	2,557			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	48	110			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

	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	2,453	102	4,855	1.00
2.00	HMO and other (see instructions)			498	699		2.00
3.00	HMO IPF Subprovider				358		3.00
4.00	HMO IRF Subprovider				12		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	2,453	102	4,855	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	139	62	792	16.00
17.00	SUBPROVIDER - IRF	0.00	0	377	2	451	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 7/29/2021 2:33 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	103,341,470	0	103,341,470	3,129,835.00	33.02	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		118,625	0	118,625	644.00	184.20	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		4,434,009	0	4,434,009	22,694.00	195.38	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)		857,653	0	857,653	15,600.00	54.98	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)		35,245,075	0	35,245,075	855,690.00	41.19	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,165,304	0	1,165,304	17,239.00	67.60	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		507,431	0	507,431	5,941.00	85.41	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		0	0	0	0.00	0.00	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)		20,123,842	0	20,123,842			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		8,274,851	0	8,274,851			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		12,693	0	12,693			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		460,054	0	460,054			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)		0	0	0			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

		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	5,451,958	0	5,451,958	276,832.00	19.69	26.00
27.00	Administrative & General	5.00	7,107,356	0	7,107,356	198,100.00	35.88	27.00
28.00	Administrative & General under contract (see inst.)		1,145,401	0	1,145,401	10,340.00	110.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,270,238	0	2,270,238	91,880.00	24.71	30.00
31.00	Laundry & Linen Service	8.00	215,736	0	215,736	15,290.00	14.11	31.00
32.00	Housekeeping	9.00	2,089,015	0	2,089,015	133,640.00	15.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,674,977	-1,127,487	547,490	32,936.00	16.62	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,127,487	1,127,487	67,827.00	16.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,332,664	0	2,332,664	64,250.00	36.31	38.00
39.00	Central Services and Supply	14.00	367,400	0	367,400	21,152.00	17.37	39.00
40.00	Pharmacy	15.00	2,911,505	0	2,911,505	69,810.00	41.71	40.00
41.00	Medical Records & Medical Records Library	16.00	3,552,741	0	3,552,741	126,916.00	27.99	41.00
42.00	Social Service	17.00	525,313	0	525,313	15,611.00	33.65	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

		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)		99,195,209	0	99,195,209	3,101,881.00	31.98	1.00
2.00	Excluded area salaries (see instructions)		35,245,075	0	35,245,075	855,690.00	41.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)		63,950,134	0	63,950,134	2,246,191.00	28.47	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,672,735	0	1,672,735	23,180.00	72.16	4.00
5.00	Subtotal wage-related costs (see inst.)		20,136,535	0	20,136,535	0.00	31.49	5.00
6.00	Total (sum of lines 3 thru 5)		85,759,404	0	85,759,404	2,269,371.00	37.79	6.00
7.00	Total overhead cost (see instructions)		29,644,304	0	29,644,304	1,124,584.00	26.36	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 7/29/2021 2:33 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,717,816	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)	15,466,820	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	313,988	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	156,927	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)	323,938	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	196,984	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	6,936,071	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	453,766	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	50,915	22.00
23.00	Tuition Reimbursement	254,214	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	28,871,439	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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 7/29/2021 2:33 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	1,165,304	28,871,439	1.00
2.00	Hospital	1,165,304	28,871,439	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2020 To 12/31/2020	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 7/29/2021 2:33 pm
		Hospice I	

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	4,987	30	152	5,169	11.00
12.00	Hospice Inpatient Respite Care	5	0	2	7	12.00
13.00	Hospice General Inpatient Care	326	15	40	381	13.00
14.00	Total Hospice Days	5,318	45	194	5,557	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/29/2021 2:33 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)	0.255285	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,815,671	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	81,878,579	6.00
7.00	Medicaid cost (line 1 times line 6)	20,902,373	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)	9,086,702	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)	9,086,702	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)	7,840,747	1,120,098	8,960,845	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,001,625	1,120,098	3,121,723	21.00
22.00	Payments received from patients for amounts previously written off as charity care	9,640	2,260	11,900	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,991,985	1,117,838	3,109,823	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)	13,979,271	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	750,314	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,154,329	27.01
28.00	Non-Medicare bad debt expense (see instructions)	12,824,942	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,678,030	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,787,853	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,874,555	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 2:33 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		18,044,284	18,044,284	6,029,941	24,074,225	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		95,145	95,145	0	95,145	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	626,130	1,896,503	2,522,633	26,852,259	29,374,892	4.00
4.01	00401	COMMUNICATIONS	276,769	111,689	388,458	-109,207	279,251	4.01
4.02	00402	PURCHASING & RECEIVING	667,262	573,059	1,240,321	-271,103	969,218	4.02
4.03	00403	REGISTRATION	1,511,097	537,986	2,049,083	-520,575	1,528,508	4.03
4.04	00404	PATIENT ACCOUNTS	2,370,700	2,087,874	4,458,574	-562,411	3,896,163	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,107,356	23,259,633	30,366,989	-2,217,481	28,149,508	5.00
7.00	00700	OPERATION OF PLANT	2,270,238	4,364,217	6,634,455	-660,003	5,974,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	215,736	205,777	421,513	-103,947	317,566	8.00
9.00	00900	HOUSEKEEPING	2,089,015	982,189	3,071,204	-778,382	2,292,822	9.00
10.00	01000	DIETARY	1,674,977	1,924,813	3,599,790	-2,606,143	993,647	10.00
11.00	01100	CAFETERIA	0	0	0	2,046,292	2,046,292	11.00
13.00	01300	NURSING ADMINISTRATION	2,332,664	1,606,086	3,938,750	-755,201	3,183,549	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	367,400	308,230	675,630	-83,853	591,777	14.00
15.00	01500	PHARMACY	2,911,505	18,692,287	21,603,792	-18,378,116	3,225,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,552,741	1,679,674	5,232,415	-1,043,381	4,189,034	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	525,313	342,802	868,115	-143,672	724,443	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	857,653	857,653	0	857,653	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,245,712	711,627	1,957,339	-335,314	1,622,025	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	233,957	79,831	313,788	-58,215	255,573	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,446,561	2,205,395	6,651,956	-987,587	5,664,369	30.00
31.00	03100	INTENSIVE CARE UNIT	3,183,737	1,546,188	4,729,925	-801,651	3,928,274	31.00
40.00	04000	SUBPROVIDER - IPF	2,006,922	599,015	2,605,937	-423,648	2,182,289	40.00
41.00	04100	SUBPROVIDER - IRF	1,594,965	698,748	2,293,713	-496,851	1,796,862	41.00
43.00	04300	NURSERY	294,776	101,637	396,413	-76,521	319,892	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,057,616	5,591,627	8,649,243	-3,409,429	5,239,814	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	751,774	992,223	1,743,997	-475,505	1,268,492	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,258,162	393,037	1,651,199	-577,512	1,073,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,579,864	3,717,741	7,297,605	-1,819,288	5,478,317	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,550,937	1,852,636	4,403,573	-648,104	3,755,469	55.00
60.00	06000	LABORATORY	2,253,807	5,603,492	7,857,299	-661,911	7,195,388	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,360,272	1,652,479	4,012,751	-839,172	3,173,579	65.00
66.00	06600	PHYSICAL THERAPY	3,714,916	1,088,055	4,802,971	-947,787	3,855,184	66.00
69.00	06900	ELECTROCARDIOLOGY	5,230,152	3,324,663	8,554,815	-2,754,895	5,799,920	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	452,485	216,665	669,150	-78,603	590,547	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,036,742	4,036,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,970,233	3,970,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,729,102	17,729,102	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,059,520	1,947,679	3,007,199	-1,236,364	1,770,835	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	491,821	491,821	-4,415	487,406	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,719	17,007	103,726	-16,580	87,146	90.00
90.01	04950	WOUND CLINIC	393,276	1,738,502	2,131,778	-1,200,963	930,815	90.01
91.00	09100	EMERGENCY	3,589,323	2,801,123	6,390,446	-872,105	5,518,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	87,883	73,220	161,103	-16,474	144,629	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		5,921,611	5,921,611	-5,921,611	0	113.00
116.00	11600	HOSPICE	438,842	432,030	870,872	-94,001	776,871	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,371,081	121,367,953	193,739,034	7,676,588	201,415,622	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,058,309	14,542,904	35,601,213	-5,002,509	30,598,704	192.00
192.01	19201	FP PETERSBURG	251,821	126,530	378,351	-57,384	320,967	192.01
192.02	19202	PEDIATRICS	1,345,787	826,281	2,172,068	-390,984	1,781,084	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,321,765	636,213	1,957,978	-367,347	1,590,631	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	342	6,888	7,230	-112	7,118	194.00
194.01	07960	CCBHC GRANTS	258,500	155,704	414,204	-57,184	357,020	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	224,378	542,138	766,516	-59,266	707,250	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.03	07953	MH RESIDENTIAL	458,120	167,915	626,035	-129,882	496,153	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	30,491	30,491	0	30,491	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	6,051,367	2,117,256	8,168,623	-1,611,920	6,556,703	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	103,341,470	140,520,273	243,861,743	0	243,861,743	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 2:33 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	-2,275,869	21,798,356	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	95,145	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-830	29,374,062	4.00
4.01	00401	COMMUNICATIONS	0	279,251	4.01
4.02	00402	PURCHASING & RECEIVING	-181,016	788,202	4.02
4.03	00403	REGISTRATION	0	1,528,508	4.03
4.04	00404	PATIENT ACCOUNTS	-61,274	3,834,889	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-12,727,715	15,421,793	5.00
7.00	00700	OPERATION OF PLANT	-48,299	5,926,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-10,732	306,834	8.00
9.00	00900	HOUSEKEEPING	-31,608	2,261,214	9.00
10.00	01000	DIETARY	0	993,647	10.00
11.00	01100	CAFETERIA	-991,534	1,054,758	11.00
13.00	01300	NURSING ADMINISTRATION	-37,171	3,146,378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	591,777	14.00
15.00	01500	PHARMACY	-91,021	3,134,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-66,162	4,122,872	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OH	-1,075	723,368	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	857,653	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-120,395	1,501,630	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	-35,788	219,785	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	5,664,369	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,928,274	31.00
40.00	04000	SUBPROVIDER - IPF	-405,415	1,776,874	40.00
41.00	04100	SUBPROVIDER - IRF	0	1,796,862	41.00
43.00	04300	NURSERY	0	319,892	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-2,131,523	3,108,291	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	1,268,492	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,073,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,630	5,441,687	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,268,528	2,486,941	55.00
60.00	06000	LABORATORY	0	7,195,388	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-867,008	2,306,571	65.00
66.00	06600	PHYSICAL THERAPY	-1,466	3,853,718	66.00
69.00	06900	ELECTROCARDIOLOGY	-3,671,337	2,128,583	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-89,451	501,096	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,036,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,970,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-300,191	17,428,911	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-83,876	1,686,959	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	-202,523	284,883	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	87,146	90.00
90.01	04950	WOUND CLINIC	-806	930,009	90.01
91.00	09100	EMERGENCY	-1,253,253	4,265,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	144,629	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-29	776,842	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,992,525	174,423,097	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,598,704	192.00
192.01	19201	FP PETERSBURG	0	320,967	192.01
192.02	19202	PEDIATRICS	0	1,781,084	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,590,631	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	7,118	194.00
194.01	07960	CCBHC GRANTS	0	357,020	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	707,250	194.02
194.03	07953	MH RESIDENTIAL	0	496,153	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.04	07954	UNUSED SPACE	0	0	194.04
194.05	07955	MOB	0	30,491	194.05
194.06	07956	FOUNDATION	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	6,556,703	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,992,525	216,869,218	200.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/29/2021 2:33 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00		17,729,102	1.00
2.00		0.00	0	0	2.00
	0		0	17,729,102	
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,036,742	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,970,233	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	49,853	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	8,056,828	
	C - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,879,866	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
	0		0	26,879,866	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,652,975	1.00
2.00	PATIENT ACCOUNTS	4.04	0	268,636	2.00
	0		0	5,921,611	
	E - INSURANCE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	376,966	1.00
	0		0	376,966	
	F - DIETARY RECLASS				
1.00	CAFETERIA	11.00	1,127,487	918,805	1.00
	0		1,127,487	918,805	
	G - OB RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	278,683	26,674	1.00
	0		278,683	26,674	
500.00	Grand Total: Increases		1,406,170	59,909,852	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00		17,672,898	0		1.00
2.00	NURSING ADMINISTRATION	13.00		56,204	0		2.00
	0		0	17,729,102			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	27,607	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		563	0		2.00
3.00	OPERATION OF PLANT	7.00		1,493	0		3.00
4.00	HOUSEKEEPING	9.00		9	0		4.00
5.00	NURSING ADMINISTRATION	13.00		63,834	0		5.00
6.00	PHARMACY	15.00		17,696	0		6.00
7.00	ADULTS & PEDIATRICS	30.00		102,958	0		7.00
8.00	INTENSIVE CARE UNIT	31.00		44,995	0		8.00
9.00	SUBPROVIDER - IPF	40.00		234	0		9.00
10.00	SUBPROVIDER - IRF	41.00		2,172	0		10.00
11.00	NURSERY	43.00		5,753	0		11.00
12.00	OPERATING ROOM	50.00		2,580,986	0		12.00
13.00	ENDOSCOPY	51.01		279,069	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00		17,993	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00		838,526	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00		10,650	0		16.00
17.00	LABORATORY	60.00		5,033	0		17.00
18.00	RESPIRATORY THERAPY	65.00		219,014	0		18.00
19.00	PHYSICAL THERAPY	66.00		12,431	0		19.00
20.00	ELECTROCARDIOLOGY	69.00		1,662,239	0		20.00
21.00	NEURODIAGNOSTICS	70.01		1,889	0		21.00
22.00	ASC (NON-DISTINCT PART)	75.00		950,049	0		22.00
23.00	INPATIENT DIALYSIS	76.01		4,415	0		23.00
24.00	WOUND CLINIC	90.01		1,127,664	0		24.00
25.00	EMERGENCY	91.00		79,556	0		25.00
	0		0	8,056,828			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNICATIONS	4.01		109,207	0		1.00
2.00	PURCHASING & RECEIVING	4.02		271,103	0		2.00
3.00	REGISTRATION	4.03		520,575	0		3.00
4.00	PATIENT ACCOUNTS	4.04		831,047	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00		1,839,952	0		5.00
6.00	OPERATION OF PLANT	7.00		658,510	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00		103,947	0		7.00
8.00	HOUSEKEEPING	9.00		778,373	0		8.00
9.00	DIETARY	10.00		559,851	0		9.00
10.00	NURSING ADMINISTRATION	13.00		635,163	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00		133,706	0		11.00
12.00	PHARMACY	15.00		687,522	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00		1,043,381	0		13.00
14.00	MENTAL HEALTH OH	17.01		143,672	0		14.00
15.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00		335,314	0		15.00
16.00	PARAMED ED PRGM-LAB	23.01		58,215	0		16.00
17.00	ADULTS & PEDIATRICS	30.00		1,189,986	0		17.00
18.00	INTENSIVE CARE UNIT	31.00		756,656	0		18.00
19.00	SUBPROVIDER - IPF	40.00		423,414	0		19.00
20.00	SUBPROVIDER - IRF	41.00		494,679	0		20.00
21.00	NURSERY	43.00		70,768	0		21.00
22.00	OPERATING ROOM	50.00		828,443	0		22.00
23.00	ENDOSCOPY	51.01		196,436	0		23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00		254,162	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00		980,762	0		25.00
26.00	RADIOLOGY-THERAPEUTIC	55.00		637,454	0		26.00
27.00	LABORATORY	60.00		656,878	0		27.00
28.00	RESPIRATORY THERAPY	65.00		620,158	0		28.00
29.00	PHYSICAL THERAPY	66.00		935,356	0		29.00
30.00	ELECTROCARDIOLOGY	69.00		1,092,656	0		30.00
31.00	NEURODIAGNOSTICS	70.01		76,714	0		31.00
32.00	ASC (NON-DISTINCT PART)	75.00		286,315	0		32.00
33.00	CLINIC	90.00		16,580	0		33.00
34.00	WOUND CLINIC	90.01		73,299	0		34.00
35.00	EMERGENCY	91.00		792,549	0		35.00
36.00	DURABLE MEDICAL EQUIP-RENTED	96.00		16,474	0		36.00
37.00	HOSPICE	116.00		94,001	0		37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192.00		5,002,509	0		38.00
39.00	FP PETERSBURG	192.01		57,384	0		39.00
40.00	PEDIATRICS	192.02		390,984	0		40.00
41.00	WASHINGTON PRIMARY CARE	192.03		367,347	0		41.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/29/2021 2:33 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
42.00	COMMUNITY HEALTH SERVICES	194.00		112	0	42.00
43.00	CCBHC GRANTS	194.01		57,184	0	43.00
44.00	MARKETING AND PUBLIC RELATIONS	194.02		59,266	0	44.00
45.00	MH RESIDENTIAL	194.03		129,882	0	45.00
46.00	COMMUNITY MENTAL HEALTH CENTER	194.09		1,611,920	0	46.00
	0		0	26,879,866		
	D - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	5,921,611	11	1.00
2.00		0.00	0	0	0	2.00
	0		0	5,921,611		
	E - INSURANCE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	376,966	12	1.00
	0		0	376,966		
	F - DIETARY RECLASS					
1.00	DIETARY	10.00	1,127,487	918,805	0	1.00
	0		1,127,487	918,805		
	G - OB RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	278,683	26,674	0	1.00
	0		278,683	26,674		
500.00	Grand Total: Decreases		1,406,170	59,909,852		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,581,448	0	0	0	0	1.00
2.00	Land Improvements	10,609,282	82,948	0	82,948	0	2.00
3.00	Buildings and Fixtures	163,818,192	5,594,516	0	5,594,516	0	3.00
4.00	Building Improvements	850,562	30,100	0	30,100	369,795	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	218,389,269	12,079,989	0	12,079,989	7,875,629	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	400,248,753	17,787,553	0	17,787,553	8,245,424	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	400,248,753	17,787,553	0	17,787,553	8,245,424	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,581,448	0	1.00
2.00	Land Improvements	10,692,230	0	2.00
3.00	Buildings and Fixtures	169,412,708	0	3.00
4.00	Building Improvements	510,867	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	222,593,629	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	409,790,882	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	409,790,882	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 7/29/2021 2:33 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	18,044,284	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,145	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	18,139,429	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	18,044,284	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	95,145	2.00
3.00	Total (sum of lines 1-2)	0	18,139,429	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III | Date/Time Prepared: 7/29/2021 2:33 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	187,197,253	0	187,197,253	0.456812	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	222,593,629	0	222,593,629	0.543188	0	2.00
3.00	Total (sum of lines 1-2)	409,790,882	0	409,790,882	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	18,044,284	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	95,145	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	18,139,429	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,377,106	376,966	0	0	21,798,356	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	95,145	2.00
3.00	Total (sum of lines 1-2)	3,377,106	376,966	0	0	21,893,501	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 2:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,275,869	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-10,390	PURCHASING & RECEIVING	4.02	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)	B	-27,601	OPERATION OF PLANT	7.00	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	-9,502,816			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-269,167	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-300,191	DRUGS CHARGED TO PATIENTS	73.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-46,606	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 2:33 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	
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
33.00	MISC INCOME	B	-830	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC INCOME	B	-170,626	PURCHASING & RECEIVING	4.02	0	33.01
33.02	MISC INCOME	B	-1,166	PATIENT ACCOUNTS	4.04	0	33.02
33.03	MISC INCOME	B	-965,314	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC INCOME	B	-20,698	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-10,732	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	MISC INCOME	B	-31,608	HOUSEKEEPING	9.00	0	33.06
33.07	MISC INCOME	B	-35,846	NURSING ADMINISTRATION	13.00	0	33.07
33.08	MISC INCOME	B	-79,355	PHARMACY	15.00	0	33.08
33.09	MISC INCOME	B	-66,162	MEDICAL RECORDS & LIBRARY	16.00	0	33.09
33.10	MISC INCOME	B	-8,808	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.10
33.11	MISC INCOME	B	-35,788	PARAMED ED PRGM-LAB	23.01	0	33.11
33.12	MISC INCOME	B	-71,119	OPERATING ROOM	50.00	0	33.12
33.13	MISC INCOME	B	-35,745	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	MISC INCOME	B	-189,712	ELECTROCARDIOLOGY	69.00	0	33.14
33.15	MISC INCOME	B	-150	ASC (NON-DISTINCT PART)	75.00	0	33.15
33.16	MISC INCOME	B	-1,756	WOUND CLINIC	90.01	0	33.16
33.17	MISC INCOME	B	-29	HOSPICE	116.00	0	33.17
33.18	ADVERTISING	A	-4,004	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	ADVERTISING	A	-1,075	MENTAL HEALTH OH	17.01	0	33.19
33.20	ADVERTISING	A	-1,466	PHYSICAL THERAPY	66.00	0	33.20
33.21	ADVERTISING	A	-44	NEURODIAGNOSTICS	70.01	0	33.21
33.22	PHYSICIAN BILLING COSTS	A	-60,108	PATIENT ACCOUNTS	4.04	0	33.22
33.23	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	GME CONSORTIUM FEES	A	200,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.24
33.25	AHA LOBBYING OFFSET	A	-10,007	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	IHA LOBBYING OFFSET	A	-4,482	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	INDIANA CHAMBER LOBBYING OFFSET	A	-184	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	IHRA LOBBYING OFFSET	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	PROVIDER ASSESSMENT FEE	A	-11,435,801	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	RENTAL	B	-42,507	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	RENTAL	B	-19,620	OPERATING ROOM	50.00	0	33.31
33.32	RENTAL	B	-1,920	ELECTROCARDIOLOGY	69.00	0	33.32
33.33	RENTAL	B	-202,523	INPATIENT DIALYSIS	76.01	0	33.33
33.34	PHYSICIAN LOAN EXPENSE	A	-156,256	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	PHYSICIAN LOAN EXPENSE	A	-6,833	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	PHYSICIAN LOAN EXPENSE	A	-10,000	OPERATING ROOM	50.00	0	33.36
33.37	PHYSICIAN LOAN EXPENSE	A	-20,000	RADIOLOGY-THERAPEUTIC	55.00	0	33.37
33.38	PHYSICIAN LOAN EXPENSE	A	-20,000	ELECTROCARDIOLOGY	69.00	0	33.38
33.40	OTHER REVENUE	B	-311,587	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.40
33.41	OTHER MISC FEES	B	-675,761	CAFETERIA	11.00	0	33.41
33.42	DONATIONS EXPENSE	A	-91,118	ADMINISTRATIVE & GENERAL	5.00	0	33.42
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,992,525				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/29/2021 2:33 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	ADMINISTRATIVE & GENERAL	204,181	20,181	184,000	211,500	1,496	1.00
2.00	13.00	NURSING ADMINISTRATION	5,392	192	5,200	211,500	40	2.00
3.00	15.00	PHARMACY	19,166	11,666	7,500	211,500	108	3.00
4.00	40.00	SUBPROVIDER - IPF	429,819	368,349	61,470	211,500	240	4.00
5.00	50.00	OPERATING ROOM	2,073,549	1,992,709	80,840	246,400	361	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	885	885	0	211,500	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	1,268,790	1,241,665	27,125	271,900	155	7.00
8.00	60.00	LABORATORY	140,001	0	140,001	211,500	2,682	8.00
9.00	65.00	RESPIRATORY THERAPY	879,008	867,008	12,000	271,900	290	9.00
10.00	69.00	ELECTROCARDIOLOGY	3,464,077	3,454,472	9,605	211,500	43	10.00
11.00	70.01	NEURODIAGNOSTICS	97,847	79,847	18,000	211,500	83	11.00
12.00	75.00	ASC (NON-DISTINCT PART)	113,011	75,010	38,001	211,500	288	12.00
13.00	76.01	INPATIENT DIALYSIS	36,807	0	36,807	211,500	375	13.00
14.00	90.01	WOUND CLINIC	-950	-950	0	211,500	0	14.00
15.00	91.00	EMERGENCY	1,292,050	1,253,253	38,797	211,500	424	15.00
200.00			10,023,633	9,364,287	659,346		6,585	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	152,117	7,606	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	4,067	203	0	0	0	2.00
3.00	15.00	PHARMACY	10,982	549	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	24,404	1,220	0	0	0	4.00
5.00	50.00	OPERATING ROOM	42,765	2,138	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	20,262	1,013	0	0	0	7.00
8.00	60.00	LABORATORY	272,713	13,636	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	37,909	1,895	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	4,372	219	0	0	0	10.00
11.00	70.01	NEURODIAGNOSTICS	8,440	422	0	0	0	11.00
12.00	75.00	ASC (NON-DISTINCT PART)	29,285	1,464	0	0	0	12.00
13.00	76.01	INPATIENT DIALYSIS	38,131	1,907	0	0	0	13.00
14.00	90.01	WOUND CLINIC	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	43,113	2,156	0	0	0	15.00
200.00			688,560	34,428	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	152,117	31,883	52,064		1.00
2.00	13.00	NURSING ADMINISTRATION	0	4,067	1,133	1,325		2.00
3.00	15.00	PHARMACY	0	10,982	0	11,666		3.00
4.00	40.00	SUBPROVIDER - IPF	0	24,404	37,066	405,415		4.00
5.00	50.00	OPERATING ROOM	0	42,765	38,075	2,030,784		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	885		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	20,262	6,863	1,248,528		7.00
8.00	60.00	LABORATORY	0	272,713	0	0		8.00
9.00	65.00	RESPIRATORY THERAPY	0	37,909	0	867,008		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	4,372	5,233	3,459,705		10.00
11.00	70.01	NEURODIAGNOSTICS	0	8,440	9,560	89,407		11.00
12.00	75.00	ASC (NON-DISTINCT PART)	0	29,285	8,716	83,726		12.00
13.00	76.01	INPATIENT DIALYSIS	0	38,131	0	0		13.00
14.00	90.01	WOUND CLINIC	0	0	0	-950		14.00
15.00	91.00	EMERGENCY	0	43,113	0	1,253,253		15.00
200.00			0	688,560	138,529	9,502,816		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	21,798,356	21,798,356				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	95,145		95,145			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,374,062	119,823	523	29,494,408		4.00
4.01	00401	COMMUNICATIONS	279,251	0	0	79,473	358,724	4.01
4.02	00402	PURCHASING & RECEIVING	788,202	285,265	1,245	191,602	2,920	4.02
4.03	00403	REGISTRATION	1,528,508	278,586	1,216	433,907	5,840	4.03
4.04	00404	PATIENT ACCOUNTS	3,834,889	0	0	680,739	7,377	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	15,421,793	1,182,117	5,160	2,040,856	26,128	5.00
7.00	00700	OPERATION OF PLANT	5,926,153	5,913,049	25,811	651,892	19,519	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	306,834	129,780	566	61,948	0	8.00
9.00	00900	HOUSEKEEPING	2,261,214	180,548	788	599,854	5,840	9.00
10.00	01000	DIETARY	993,647	0	0	157,210	1,383	10.00
11.00	01100	CAFETERIA	1,054,758	308,529	1,347	323,755	2,920	11.00
13.00	01300	NURSING ADMINISTRATION	3,146,378	240,608	1,050	669,817	3,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	591,777	97,766	427	105,498	1,383	14.00
15.00	01500	PHARMACY	3,134,655	147,352	643	836,030	5,994	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,122,872	112,874	493	1,020,159	9,068	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	723,368	64,200	280	150,842	34,581	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	857,653	249,998	1,091	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,501,630	0	0	357,702	7,685	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	219,785	0	0	67,180	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,664,369	1,508,760	6,585	1,356,840	25,360	30.00
31.00	03100	INTENSIVE CARE UNIT	3,928,274	516,409	2,254	914,201	15,523	31.00
40.00	04000	SUBPROVIDER - IPF	1,776,874	321,221	1,402	576,282	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,796,862	423,720	1,849	457,989	11,373	41.00
43.00	04300	NURSERY	319,892	0	0	84,644	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,108,291	592,118	2,584	877,985	23,054	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,268,492	301,580	1,316	215,870	4,150	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,073,687	0	0	281,254	10,298	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,441,687	533,956	2,331	1,027,947	10,298	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,486,941	443,238	1,935	732,494	5,840	55.00
60.00	06000	LABORATORY	7,195,388	179,858	785	647,174	6,763	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,306,571	139,958	611	677,745	6,148	65.00
66.00	06600	PHYSICAL THERAPY	3,853,718	376,500	1,643	1,066,727	4,150	66.00
69.00	06900	ELECTROCARDIOLOGY	2,128,583	448,069	1,956	1,501,822	13,064	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	501,096	189,963	829	129,930	3,381	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,036,742	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,970,233	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,428,911	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,686,959	0	0	304,238	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	284,883	211,502	923	0	461	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,146	55,550	242	24,901	1,691	90.00
90.01	04950	WOUND CLINIC	930,009	73,343	320	112,928	1,691	90.01
91.00	09100	EMERGENCY	4,265,088	583,320	2,546	1,030,663	16,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	144,629	9,710	42	25,235	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	776,842	119,799	523	126,012	3,689	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,423,097	16,339,069	71,316	20,601,345	297,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,598,704	3,154,472	13,769	6,046,839	56,561	192.00
192.01	19201	FP PETERSBURG	320,967	91,309	399	72,310	0	192.01
192.02	19202	PEDIATRICS	1,781,084	0	0	386,439	3,228	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,590,631	167,585	731	379,541	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
194.00	07950	COMMUNITY HEALTH SERVICES	7,118	10,228	45	98	461	194.00
194.01	07960	CCBHC GRANTS	357,020	0	0	74,227	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	707,250	41,650	182	64,429	768	194.02
194.03	07953	MH RESIDENTIAL	496,153	499,305	2,179	131,548	0	194.03
194.04	07954	UNUSED SPACE	0	502,016	2,191	0	0	194.04
194.05	07955	MOB	30,491	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	11,485	50	0	307	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	116,127	507	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	6,556,703	865,110	3,776	1,737,632	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	216,869,218	21,798,356	95,145	29,494,408	358,724	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,269,234					4.02
4.03	00403	REGISTRATION	593	2,248,650				4.03
4.04	00404	PATIENT ACCOUNTS	767	0	4,523,772			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	4,892	0	0	18,680,946	18,680,946	5.00
7.00	00700	OPERATION OF PLANT	10,326	0	0	12,546,750	1,182,644	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,807	0	0	504,935	47,595	8.00
9.00	00900	HOUSEKEEPING	13,106	0	0	3,061,350	288,560	9.00
10.00	01000	DIETARY	28,573	0	0	1,180,813	111,302	10.00
11.00	01100	CAFETERIA	58,012	0	0	1,749,321	164,889	11.00
13.00	01300	NURSING ADMINISTRATION	15,325	0	0	4,076,252	384,223	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,130	0	0	802,981	75,688	14.00
15.00	01500	PHARMACY	4,108	0	0	4,128,782	389,175	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	368	0	0	5,265,834	496,352	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	271	0	0	973,542	91,765	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,108,742	104,509	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,412	0	0	1,870,429	176,305	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	210	0	0	287,175	27,069	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,142	111,835	225,005	8,924,896	841,252	30.00
31.00	03100	INTENSIVE CARE UNIT	21,566	58,017	116,726	5,572,970	525,303	31.00
40.00	04000	SUBPROVIDER - IPF	1,598	31,440	63,256	2,772,073	261,293	40.00
41.00	04100	SUBPROVIDER - IRF	5,607	26,663	53,643	2,777,706	261,824	41.00
43.00	04300	NURSERY	1,351	4,923	9,904	420,714	39,656	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,091	141,709	285,110	5,073,942	478,265	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	26,973	38,025	76,505	1,932,911	182,194	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,217	18,853	37,932	1,427,241	134,530	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,220	306,837	616,956	7,959,232	750,229	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,295	82,180	165,342	3,924,265	369,897	55.00
60.00	06000	LABORATORY	161,202	258,622	520,333	8,970,125	845,515	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,314	49,893	100,381	3,285,621	309,699	65.00
66.00	06600	PHYSICAL THERAPY	3,741	87,496	176,036	5,570,011	525,024	66.00
69.00	06900	ELECTROCARDIOLOGY	9,499	138,535	278,724	4,520,252	426,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,289	19,037	38,301	884,826	83,403	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	276,093	15,186	30,554	4,358,575	410,835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	270,664	36,831	74,103	4,351,831	410,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	305,987	615,627	18,350,525	1,729,702	73.00
75.00	07500	ASC (NON-DISTINCT PART)	23,786	76,873	154,665	2,246,521	211,755	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	144	3,670	7,384	508,967	47,975	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29	338	681	170,578	16,079	90.00
90.01	04950	WOUND CLINIC	6,664	16,072	32,336	1,173,363	110,600	90.01
91.00	09100	EMERGENCY	20,262	164,921	331,811	6,415,364	604,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,729	1,522	3,062	187,929	17,714	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,212	7,980	16,056	1,052,113	99,171	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,092,588	2,003,445	4,030,433	159,070,403	13,232,970	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	130,676	180,466	363,087	40,544,574	3,821,609	192.00
192.01	19201	FP PETERSBURG	790	2,197	4,420	492,392	46,412	192.01
192.02	19202	PEDIATRICS	27,694	12,199	24,543	2,235,187	210,686	192.02
192.03	19203	WASHINGTON PRIMARY CARE	11,629	10,836	21,802	2,182,755	205,744	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	138	0	0	18,088	1,705	194.00
194.01	07960	CCBHC GRANTS	580	0	0	431,827	40,704	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	115	0	0	814,394	76,764	194.02
194.03	07953	MH RESIDENTIAL	1,685	1,628	3,276	1,135,774	107,057	194.03
194.04	07954	UNUSED SPACE	0	0	0	504,207	47,526	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
194.05	07955	MOB	0	0	0	30,491	2,874	194.05
194.06	07956	FOUNDATION	0	0	0	11,842	1,116	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	116,634	10,994	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	3,339	37,879	76,211	9,280,650	874,785	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,269,234	2,248,650	4,523,772	216,869,218	18,680,946	202.00

		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	13,729,394					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,094	679,624				8.00
9.00	00900	HOUSEKEEPING	176,812	44,488	3,571,210			9.00
10.00	01000	DIETARY	0	9,081	93,025	1,394,221		10.00
11.00	01100	CAFETERIA	302,145	0	22,397	0	2,238,752	11.00
13.00	01300	NURSING ADMINISTRATION	235,629	0	0	0	68,270	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,743	9,440	40,366	0	22,475	14.00
15.00	01500	PHARMACY	144,302	0	31,616	0	74,178	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,538	0	30,210	0	134,857	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	62,871	12,998	96,619	0	16,588	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	244,824	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	54,169	0	19,961	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	7,044	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,477,538	234,088	878,479	645,199	198,429	30.00
31.00	03100	INTENSIVE CARE UNIT	505,722	82,775	268,242	275,366	113,119	31.00
40.00	04000	SUBPROVIDER - IPF	314,574	0	0	198,204	71,525	40.00
41.00	04100	SUBPROVIDER - IRF	414,951	38,812	158,653	275,452	66,038	41.00
43.00	04300	NURSERY	0	1,697	9,219	0	9,089	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	579,865	23,512	200,426	0	72,642	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	295,339	18,417	53,284	0	27,967	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,377	12,240	0	31,043	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	522,906	44,840	166,727	0	111,043	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	434,066	3,037	0	0	66,379	55.00
60.00	06000	LABORATORY	176,136	0	50,575	0	104,063	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	137,062	246	38,023	0	67,796	65.00
66.00	06600	PHYSICAL THERAPY	368,709	7,218	96,515	0	114,297	66.00
69.00	06900	ELECTROCARDIOLOGY	438,796	12,801	146,934	0	95,546	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	186,032	9,259	37,293	0	14,364	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	23,532	156,362	0	40,182	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	207,126	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,400	5	57,711	0	3,601	90.00
90.01	04950	WOUND CLINIC	71,825	5,849	18,490	0	11,416	90.01
91.00	09100	EMERGENCY	571,249	61,647	236,626	0	127,928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	9,509	0	0	0	3,608	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	117,320	0	48,336	0	14,895	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,383,083	654,119	3,002,537	1,394,221	1,708,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,089,191	25,505	548,099	0	410,196	192.00
192.01	19201	FP PETERSBURG	89,420	0	0	0	9,092	192.01
192.02	19202	PEDIATRICS	0	0	0	0	33,021	192.02
192.03	19203	WASHINGTON PRIMARY CARE	164,117	0	0	0	34,123	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	10,016	0	17,449	0	11	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	8,456	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	40,788	0	3,125	0	8,355	194.02
194.03	07953	MH RESIDENTIAL	488,973	0	0	0	27,155	194.03
194.04	07954	UNUSED SPACE	491,628	0	0	0	0	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	11,247	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	113,724	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	847,207	0	0	0	0	194.09
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)	13,729,394	679,624	3,571,210	1,394,221	2,238,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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
13.00	01300	NURSING ADMINISTRATION	4,764,374					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,046,693				14.00
15.00	01500	PHARMACY	0	3,820	4,771,873			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	343	0	6,038,134		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	252	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	107,283	3,173	7,760	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	195	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,066,457	24,308	111	1,254,985	0	30.00
31.00	03100	INTENSIVE CARE UNIT	607,958	20,052	24	602,737	0	31.00
40.00	04000	SUBPROVIDER - IPF	377,339	1,486	24	647,942	0	40.00
41.00	04100	SUBPROVIDER - IRF	354,919	5,214	2	376,711	0	41.00
43.00	04300	NURSERY	48,850	1,256	15	103,326	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	296,304	40,067	5,647	499,411	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	150,308	25,080	387	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,840	4,851	119	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,695	17,871	58,760	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	254,741	5,853	886	0	0	55.00
60.00	06000	LABORATORY	0	149,890	315	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,011	746	0	0	65.00
66.00	06600	PHYSICAL THERAPY	207,090	3,479	783	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,833	17,992	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	19,679	2,128	5	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	256,702	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	251,670	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,214,051	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	215,959	22,117	6,591	1,407,821	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	134	1,048	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	27	0	0	0	90.00
90.01	04950	WOUND CLINIC	16,721	6,196	3,086	258,316	0	90.01
91.00	09100	EMERGENCY	687,549	18,840	2,740	886,885	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	3,468	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	80,054	1,127	19	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,716,746	882,443	4,321,111	6,038,134	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,628	121,506	320,399	0	0	192.00
192.01	19201	FP PETERSBURG	0	735	2,778	0	0	192.01
192.02	19202	PEDIATRICS	0	25,750	91,695	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	10,813	35,726	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	129	0	0	0	194.00
194.01	07960	CCBHC GRANTS	0	539	164	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	107	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	1,566	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	3,105	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,764,374	1,046,693	4,771,873	6,038,134	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	1,254,635					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,458,075				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		2,239,080			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				321,483	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	533,450	819,189	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,952	88,993	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	569,042	350,681	538,520	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	20,803	31,946	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	321,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	31,205	47,919	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	47,550	73,020	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	221,405	339,998	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	16,345	25,101	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	91,014	139,764	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	569,042	1,370,405	2,104,450	0	321,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	87,670	134,630	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0	0	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.01	21.00	22.00	23.00	23.01	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	685,593	0	0	0	0	194.09
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,254,635	1,458,075	2,239,080	0	321,483	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	16,898,381	-1,352,639	15,545,742		30.00
31.00	03100	INTENSIVE CARE UNIT	8,721,213	-146,945	8,574,268		31.00
40.00	04000	SUBPROVIDER - IPF	6,102,703	-889,201	5,213,502		40.00
41.00	04100	SUBPROVIDER - IRF	4,730,282	0	4,730,282		41.00
43.00	04300	NURSERY	633,822	0	633,822		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,270,081	0	7,270,081		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	2,685,887	0	2,685,887		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,787,241	0	1,787,241		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,690,303	0	9,690,303		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,111,873	-52,749	5,059,124		55.00
60.00	06000	LABORATORY	10,618,102	0	10,618,102		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	3,922,328	-79,124	3,843,204		65.00
66.00	06600	PHYSICAL THERAPY	6,893,126	0	6,893,126		66.00
69.00	06900	ELECTROCARDIOLOGY	5,787,798	-120,570	5,667,228		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	1,236,989	0	1,236,989		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,026,112	0	5,026,112		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,013,700	0	5,013,700		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,294,278	0	24,294,278		73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,892,243	-561,403	4,330,840		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	806,696	-41,446	765,250		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	302,401	0	302,401		90.00
90.01	04950	WOUND CLINIC	1,675,862	0	1,675,862		90.01
91.00	09100	EMERGENCY	9,844,312	-230,778	9,613,534		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	222,228	0	222,228		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,413,035	0	1,413,035		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,580,996	-3,474,855	142,106,141		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,151,007	-222,300	48,928,707		192.00
192.01	19201	FP PETERSBURG	640,829	0	640,829		192.01
192.02	19202	PEDIATRICS	2,596,339	0	2,596,339		192.02
192.03	19203	WASHINGTON PRIMARY CARE	2,633,278	0	2,633,278		192.03
194.00	07950	COMMUNITY HEALTH SERVICES	47,398	0	47,398		194.00
194.01	07960	CCBHC GRANTS	481,690	0	481,690		194.01

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	943,533	0	943,533	194.02
194.03	07953	MH RESIDENTIAL	1,760,525	0	1,760,525	194.03
194.04	07954	UNUSED SPACE	1,043,361	0	1,043,361	194.04
194.05	07955	MOB	33,365	0	33,365	194.05
194.06	07956	FOUNDATION	24,205	0	24,205	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	241,352	0	241,352	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	11,691,340	0	11,691,340	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	216,869,218	-3,697,155	213,172,063	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	119,823	523	120,346	120,346	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	324	4.01
4.02	00402	PURCHASING & RECEIVING	0	285,265	1,245	286,510	782	4.02
4.03	00403	REGISTRATION	0	278,586	1,216	279,802	1,771	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	0	2,778	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,182,117	5,160	1,187,277	8,330	5.00
7.00	00700	OPERATION OF PLANT	0	5,913,049	25,811	5,938,860	2,661	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,780	566	130,346	253	8.00
9.00	00900	HOUSEKEEPING	0	180,548	788	181,336	2,448	9.00
10.00	01000	DIETARY	0	0	0	0	642	10.00
11.00	01100	CAFETERIA	0	308,529	1,347	309,876	1,321	11.00
13.00	01300	NURSING ADMINISTRATION	0	240,608	1,050	241,658	2,734	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,766	427	98,193	431	14.00
15.00	01500	PHARMACY	0	147,352	643	147,995	3,412	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	112,874	493	113,367	4,164	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	64,200	280	64,480	616	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	249,998	1,091	251,089	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,460	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	274	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,508,760	6,585	1,515,345	5,538	30.00
31.00	03100	INTENSIVE CARE UNIT	0	516,409	2,254	518,663	3,731	31.00
40.00	04000	SUBPROVIDER - IPF	0	321,221	1,402	322,623	2,352	40.00
41.00	04100	SUBPROVIDER - IRF	0	423,720	1,849	425,569	1,869	41.00
43.00	04300	NURSERY	0	0	0	0	345	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	592,118	2,584	594,702	3,584	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	301,580	1,316	302,896	881	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,148	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	533,956	2,331	536,287	4,196	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	443,238	1,935	445,173	2,990	55.00
60.00	06000	LABORATORY	0	179,858	785	180,643	2,641	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	139,958	611	140,569	2,766	65.00
66.00	06600	PHYSICAL THERAPY	0	376,500	1,643	378,143	4,354	66.00
69.00	06900	ELECTROCARDIOLOGY	0	448,069	1,956	450,025	6,130	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	189,963	829	190,792	530	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1,242	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	211,502	923	212,425	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	55,550	242	55,792	102	90.00
90.01	04950	WOUND CLINIC	0	73,343	320	73,663	461	90.01
91.00	09100	EMERGENCY	0	583,320	2,546	585,866	4,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	9,710	42	9,752	103	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	119,799	523	120,322	514	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,339,069	71,316	16,410,385	84,085	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,154,472	13,769	3,168,241	24,645	192.00
192.01	19201	FP PETERSBURG	0	91,309	399	91,708	295	192.01
192.02	19202	PEDIATRICS	0	0	0	0	1,577	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	167,585	731	168,316	1,549	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	10,228	45	10,273	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.01	07960	CCBHC GRANTS	0	0	0	0	303	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	41,650	182	41,832	263	194.02
194.03	07953	MH RESIDENTIAL	0	499,305	2,179	501,484	537	194.03
194.04	07954	UNUSED SPACE	0	502,016	2,191	504,207	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	11,485	50	11,535	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	116,127	507	116,634	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	865,110	3,776	868,886	7,092	194.09
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	21,798,356	95,145	21,893,501	120,346	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	324					4.01
4.02	00402	PURCHASING & RECEIVING	3	287,295				4.02
4.03	00403	REGISTRATION	5	134	281,712			4.03
4.04	00404	PATIENT ACCOUNTS	7	174	0	2,959		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	24	1,107	0	0	1,196,738	5.00
7.00	00700	OPERATION OF PLANT	18	2,337	0	0	75,757	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,314	0	0	3,049	8.00
9.00	00900	HOUSEKEEPING	5	2,966	0	0	18,484	9.00
10.00	01000	DIETARY	1	6,468	0	0	7,130	10.00
11.00	01100	CAFETERIA	3	13,131	0	0	10,562	11.00
13.00	01300	NURSING ADMINISTRATION	3	3,469	0	0	24,612	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,387	0	0	4,848	14.00
15.00	01500	PHARMACY	5	930	0	0	24,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8	83	0	0	31,795	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	31	61	0	0	5,878	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	6,695	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	7	772	0	0	11,294	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	47	0	0	1,734	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23	5,917	14,007	155	53,889	30.00
31.00	03100	INTENSIVE CARE UNIT	14	4,881	7,266	81	33,650	31.00
40.00	04000	SUBPROVIDER - IPF	0	362	3,938	44	16,738	40.00
41.00	04100	SUBPROVIDER - IRF	10	1,269	3,339	37	16,772	41.00
43.00	04300	NURSERY	0	306	617	7	2,540	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21	9,754	17,748	197	30,636	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	6,105	4,762	53	11,671	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	9	1,181	2,361	26	8,618	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9	4,351	38,513	264	48,058	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5	1,425	10,292	114	23,695	55.00
60.00	06000	LABORATORY	6	36,489	32,391	359	54,162	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6	977	6,249	69	19,839	65.00
66.00	06600	PHYSICAL THERAPY	4	847	10,958	121	33,632	66.00
69.00	06900	ELECTROCARDIOLOGY	12	2,150	17,351	192	27,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	518	2,384	26	5,343	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,497	1,902	21	26,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	61,266	4,613	51	26,276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	38,323	425	110,800	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,384	9,628	107	13,564	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	33	460	5	3,073	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2	7	42	0	1,030	90.00
90.01	04950	WOUND CLINIC	2	1,508	2,013	22	7,085	90.01
91.00	09100	EMERGENCY	15	4,586	20,655	229	38,736	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	844	191	2	1,135	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3	274	999	11	6,353	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269	247,311	251,002	2,618	847,673	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51	29,579	22,602	251	244,885	192.00
192.01	19201	FP PETERSBURG	0	179	275	3	2,973	192.01
192.02	19202	PEDIATRICS	3	6,269	1,528	17	13,496	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	2,632	1,357	15	13,179	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	31	0	0	109	194.00
194.01	07960	CCBHC GRANTS	0	131	0	0	2,607	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	26	0	0	4,917	194.02
194.03	07953	MH RESIDENTIAL	0	381	204	2	6,858	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	3,044	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
194.05	07955	MOB	0	0	0	0	184	194.05
194.06	07956	FOUNDATION	0	0	0	0	72	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	704	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	756	4,744	53	56,037	194.09
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)	324	287,295	281,712	2,959	1,196,738	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 2:33 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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,019,633					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	55,724	190,686				8.00
9.00	00900	HOUSEKEEPING	77,523	12,482	295,244			9.00
10.00	01000	DIETARY	0	2,548	7,691	24,480		10.00
11.00	01100	CAFETERIA	132,475	0	1,852	0	469,220	11.00
13.00	01300	NURSING ADMINISTRATION	103,311	0	0	0	14,309	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,978	2,649	3,337	0	4,711	14.00
15.00	01500	PHARMACY	63,269	0	2,614	0	15,547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,465	0	2,498	0	28,265	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	27,566	3,647	7,988	0	3,477	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	107,343	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	4,478	0	4,184	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	1,476	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	647,824	65,678	72,627	11,329	41,589	30.00
31.00	03100	INTENSIVE CARE UNIT	221,733	23,225	22,176	4,835	23,709	31.00
40.00	04000	SUBPROVIDER - IPF	137,925	0	0	3,480	14,991	40.00
41.00	04100	SUBPROVIDER - IRF	181,935	10,890	13,116	4,836	13,841	41.00
43.00	04300	NURSERY	0	476	762	0	1,905	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	254,241	6,597	16,570	0	15,225	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	129,491	5,167	4,405	0	5,862	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,912	1,012	0	6,506	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,268	12,581	13,784	0	23,273	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	190,316	852	0	0	13,912	55.00
60.00	06000	LABORATORY	77,227	0	4,181	0	21,811	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	60,095	69	3,143	0	14,209	65.00
66.00	06600	PHYSICAL THERAPY	161,660	2,025	7,979	0	23,956	66.00
69.00	06900	ELECTROCARDIOLOGY	192,390	3,592	12,148	0	20,026	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	81,565	2,598	3,083	0	3,011	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,603	12,927	0	8,422	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	90,814	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,852	1	4,771	0	755	90.00
90.01	04950	WOUND CLINIC	31,492	1,641	1,529	0	2,393	90.01
91.00	09100	EMERGENCY	250,463	17,297	19,563	0	26,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,169	0	0	0	756	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	51,439	0	3,996	0	3,122	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,675,553	183,530	248,230	24,480	358,055	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,354,451	7,156	45,313	0	85,970	192.00
192.01	19201	FP PETERSBURG	39,206	0	0	0	1,906	192.01
192.02	19202	PEDIATRICS	0	0	0	0	6,921	192.02
192.03	19203	WASHINGTON PRIMARY CARE	71,957	0	0	0	7,152	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	4,391	0	1,443	0	2	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	1,772	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	17,883	0	258	0	1,751	194.02
194.03	07953	MH RESIDENTIAL	214,389	0	0	0	5,691	194.03
194.04	07954	UNUSED SPACE	215,553	0	0	0	0	194.04

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		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	4,931	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	49,862	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	371,457	0	0	0	0	194.09
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)	6,019,633	190,686	295,244	24,480	469,220	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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
13.00	01300	NURSING ADMINISTRATION	390,096					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	157,535				14.00
15.00	01500	PHARMACY	0	575	259,277			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52	0	228,697		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	38	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	8,784	478	422	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	29	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,318	3,658	6	47,533	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49,778	3,018	1	22,829	0	31.00
40.00	04000	SUBPROVIDER - IPF	30,896	224	1	24,541	0	40.00
41.00	04100	SUBPROVIDER - IRF	29,060	785	0	14,268	0	41.00
43.00	04300	NURSERY	4,000	189	1	3,914	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,261	6,030	307	18,915	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,307	3,775	21	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,660	730	6	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,806	2,690	3,193	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,858	881	48	0	0	55.00
60.00	06000	LABORATORY	0	22,559	17	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	604	41	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,956	524	43	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,329	978	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,611	320	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,638	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,877	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	228,968	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,682	3,329	358	53,322	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	20	57	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4	0	0	0	90.00
90.01	04950	WOUND CLINIC	1,369	933	168	9,784	0	90.01
91.00	09100	EMERGENCY	56,295	2,835	149	33,591	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	522	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,555	170	1	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	386,196	132,816	234,786	228,697	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,900	18,287	17,408	0	0	192.00
192.01	19201	FP PETERSBURG	0	111	151	0	0	192.01
192.02	19202	PEDIATRICS	0	3,875	4,982	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,627	1,941	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	19	0	0	0	194.00
194.01	07960	CCBHC GRANTS	0	81	9	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	16	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	236	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	467	0	0	0	194.09
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)	390,096	157,535	259,277	228,697	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	113,782					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	365,127				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		31,879			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				3,560	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	51,609					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
51.01	05101	ENDOSCOPY	0					51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
60.00	06000	LABORATORY	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0					63.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	07001	NEURODIAGNOSTICS	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0					75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0					76.00
76.01	03951	INPATIENT DIALYSIS	0					76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0					90.00
90.01	04950	WOUND CLINIC	0					90.01
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0					96.00
101.00	10100	HOME HEALTH AGENCY	0					101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,609	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
192.01	19201	FP PETERSBURG	0					192.01
192.02	19202	PEDIATRICS	0					192.02
192.03	19203	WASHINGTON PRIMARY CARE	0					192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0					194.00
194.01	07960	CCBHC GRANTS	0					194.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0					194.02
194.03	07953	MH RESIDENTIAL	0					194.03
194.04	07954	UNUSED SPACE	0					194.04
194.05	07955	MOB	0					194.05
194.06	07956	FOUNDATION	0					194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0					194.07
194.08	07958	INDUSTRIAL HEALTH	0					194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	62,173					194.09
200.00		Cross Foot Adjustments		365,127	31,879	0	3,560	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	113,782	365,127	31,879	0	3,560	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,572,436	0	2,572,436		30.00
31.00	03100	INTENSIVE CARE UNIT	939,590	0	939,590		31.00
40.00	04000	SUBPROVIDER - IPF	609,724	0	609,724		40.00
41.00	04100	SUBPROVIDER - IRF	717,596	0	717,596		41.00
43.00	04300	NURSERY	15,062	0	15,062		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	998,788	0	998,788		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	487,400	0	487,400		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,169	0	38,169		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,273	0	921,273		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	710,561	0	710,561		55.00
60.00	06000	LABORATORY	432,486	0	432,486		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	248,636	0	248,636		65.00
66.00	06600	PHYSICAL THERAPY	641,202	0	641,202		66.00
69.00	06900	ELECTROCARDIOLOGY	733,616	0	733,616		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	291,784	0	291,784		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,375	0	129,375		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,083	0	130,083		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	378,516	0	378,516		73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,568	0	132,568		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	306,887	0	306,887		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	86,358	0	86,358		90.00
90.01	04950	WOUND CLINIC	134,063	0	134,063		90.01
91.00	09100	EMERGENCY	1,061,299	0	1,061,299		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	17,474	0	17,474		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	193,759	0	193,759		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,928,705	0	12,928,705		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,022,739	0	5,022,739		192.00
192.01	19201	FP PETERSBURG	136,807	0	136,807		192.01
192.02	19202	PEDIATRICS	38,668	0	38,668		192.02
192.03	19203	WASHINGTON PRIMARY CARE	269,725	0	269,725		192.03
194.00	07950	COMMUNITY HEALTH SERVICES	16,268	0	16,268		194.00
194.01	07960	CCBHC GRANTS	4,903	0	4,903		194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	66,947	0	66,947	194.02
194.03	07953	MH RESIDENTIAL	729,782	0	729,782	194.03
194.04	07954	UNUSED SPACE	722,804	0	722,804	194.04
194.05	07955	MOB	184	0	184	194.05
194.06	07956	FOUNDATION	16,538	0	16,538	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	167,200	0	167,200	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,371,665	0	1,371,665	194.09
200.00		Cross Foot Adjustments	400,566	0	400,566	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,893,501	0	21,893,501	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	884,498					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		884,498				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,862	4,862	102,715,340			4.00
4.01	00401	COMMUNICATIONS	0	0	276,769	2,334		4.01
4.02	00402	PURCHASING & RECEIVING	11,575	11,575	667,262	19	18,618,025	4.02
4.03	00403	REGISTRATION	11,304	11,304	1,511,097	38	8,705	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	2,370,700	48	11,255	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	47,966	47,966	7,107,356	170	71,766	5.00
7.00	00700	OPERATION OF PLANT	239,930	239,930	2,270,238	127	151,474	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,266	5,266	215,736	0	85,178	8.00
9.00	00900	HOUSEKEEPING	7,326	7,326	2,089,015	38	192,242	9.00
10.00	01000	DIETARY	0	0	547,490	9	419,130	10.00
11.00	01100	CAFETERIA	12,519	12,519	1,127,487	19	850,961	11.00
13.00	01300	NURSING ADMINISTRATION	9,763	9,763	2,332,664	20	224,799	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,967	3,967	367,400	9	89,914	14.00
15.00	01500	PHARMACY	5,979	5,979	2,911,505	39	60,257	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,580	4,580	3,552,741	59	5,405	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	2,605	2,605	525,313	225	3,980	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	10,144	10,144	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,245,712	50	50,055	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	233,957	0	3,077	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,220	61,220	4,725,244	165	383,474	30.00
31.00	03100	INTENSIVE CARE UNIT	20,954	20,954	3,183,737	101	316,343	31.00
40.00	04000	SUBPROVIDER - IPF	13,034	13,034	2,006,922	0	23,448	40.00
41.00	04100	SUBPROVIDER - IRF	17,193	17,193	1,594,965	74	82,251	41.00
43.00	04300	NURSERY	0	0	294,776	0	19,814	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,026	24,026	3,057,616	150	632,088	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,237	12,237	751,774	27	395,663	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	979,479	67	76,534	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,666	21,666	3,579,864	67	281,936	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,985	17,985	2,550,937	38	92,342	55.00
60.00	06000	LABORATORY	7,298	7,298	2,253,807	44	2,364,643	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,679	5,679	2,360,272	40	63,283	65.00
66.00	06600	PHYSICAL THERAPY	15,277	15,277	3,714,916	27	54,882	66.00
69.00	06900	ELECTROCARDIOLOGY	18,181	18,181	5,230,152	85	139,346	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,708	7,708	452,485	22	33,578	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,049,804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,970,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,059,520	0	348,913	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	8,582	8,582	0	3	2,110	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,254	2,254	86,719	11	427	90.00
90.01	04950	WOUND CLINIC	2,976	2,976	393,276	11	97,755	90.01
91.00	09100	EMERGENCY	23,669	23,669	3,589,323	109	297,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	394	394	87,883	0	54,703	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,861	4,861	438,842	24	17,781	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	662,980	662,980	71,744,951	1,935	16,026,853	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,997	127,997	21,058,309	368	1,916,862	192.00
192.01	19201	FP PETERSBURG	3,705	3,705	251,821	0	11,590	192.01
192.02	19202	PEDIATRICS	0	0	1,345,787	21	406,231	192.02
192.03	19203	WASHINGTON PRIMARY CARE	6,800	6,800	1,321,765	0	170,585	192.03

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
194.00	07950	COMMUNITY HEALTH SERVICES	415	415	342	3	2,029	194.00
194.01	07960	CCBHC GRANTS	0	0	258,500	0	8,502	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,690	1,690	224,378	5	1,683	194.02
194.03	07953	MH RESIDENTIAL	20,260	20,260	458,120	0	24,710	194.03
194.04	07954	UNUSED SPACE	20,370	20,370	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	466	466	0	2	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	35,103	35,103	6,051,367	0	48,980	194.09
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)	21,798,356	95,145	29,494,408	358,724	1,269,234	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.644890	0.107569	0.287147	153.694944	0.068172	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			120,346	324	287,295	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001172	0.138817	0.015431	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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION	624,437,869					4.03
4.04	00404	PATIENT ACCOUNTS	0	624,437,869				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-18,680,946	198,188,272		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	12,546,750	568,861	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	504,935	5,266	8.00
9.00	00900	HOUSEKEEPING	0	0	0	3,061,350	7,326	9.00
10.00	01000	DIETARY	0	0	0	1,180,813	0	10.00
11.00	01100	CAFETERIA	0	0	0	1,749,321	12,519	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	4,076,252	9,763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	802,981	3,967	14.00
15.00	01500	PHARMACY	0	0	0	4,128,782	5,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,265,834	4,580	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	0	0	973,542	2,605	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,108,742	10,144	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	1,870,429	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	287,175	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,056,575	31,056,575	0	8,924,896	61,220	30.00
31.00	03100	INTENSIVE CARE UNIT	16,111,220	16,111,220	0	5,572,970	20,954	31.00
40.00	04000	SUBPROVIDER - IPF	8,730,989	8,730,989	0	2,772,073	13,034	40.00
41.00	04100	SUBPROVIDER - IRF	7,404,201	7,404,201	0	2,777,706	17,193	41.00
43.00	04300	NURSERY	1,367,007	1,367,007	0	420,714	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,352,712	39,352,712	0	5,073,942	24,026	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	10,559,652	10,559,652	0	1,932,911	12,237	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,235,619	5,235,619	0	1,427,241	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,195,272	85,195,272	0	7,959,232	21,666	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	22,821,465	22,821,465	0	3,924,265	17,985	55.00
60.00	06000	LABORATORY	71,819,620	71,819,620	0	8,970,125	7,298	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	13,855,191	13,855,191	0	3,285,621	5,679	65.00
66.00	06600	PHYSICAL THERAPY	24,297,613	24,297,613	0	5,570,011	15,277	66.00
69.00	06900	ELECTROCARDIOLOGY	38,471,199	38,471,199	0	4,520,252	18,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	5,286,474	5,286,474	0	884,826	7,708	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,217,208	4,217,208	0	4,358,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,228,109	10,228,109	0	4,351,831	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,972,671	84,972,671	0	18,350,525	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	21,347,778	21,347,778	0	2,246,521	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,019,180	1,019,180	0	508,967	8,582	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	93,959	93,959	0	170,578	2,254	90.00
90.01	04950	WOUND CLINIC	4,463,175	4,463,175	0	1,173,363	2,976	90.01
91.00	09100	EMERGENCY	45,798,619	45,798,619	0	6,415,364	23,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	422,599	422,599	0	187,929	394	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,216,085	2,216,085	0	1,052,113	4,861	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	556,344,192	556,344,192	-18,680,946	140,389,457	347,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,115,535	50,115,535	0	40,544,574	127,997	192.00
192.01	19201	FP PETERSBURG	610,077	610,077	0	492,392	3,705	192.01
192.02	19202	PEDIATRICS	3,387,560	3,387,560	0	2,235,187	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	3,009,250	3,009,250	0	2,182,755	6,800	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	18,088	415	194.00
194.01	07960	CCBHC GRANTS	0	0	0	431,827	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	814,394	1,690	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
194.03	07953	MH RESIDENTIAL	452,112	452,112	0	1,135,774	20,260	194.03
194.04	07954	UNUSED SPACE	0	0	0	504,207	20,370	194.04
194.05	07955	MOB	0	0	0	30,491	0	194.05
194.06	07956	FOUNDATION	0	0	0	11,842	466	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	116,634	4,712	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	10,519,143	10,519,143	0	9,280,650	35,103	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,248,650	4,523,772		18,680,946	13,729,394	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003601	0.007245		0.094259	24.134884	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	281,712	2,959		1,196,738	6,019,633	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000451	0.000005		0.006038	10.581905	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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	880,078					8.00
9.00	00900	HOUSEKEEPING	57,610	68,564				9.00
10.00	01000	DIETARY	11,760	1,786	32,632			10.00
11.00	01100	CAFETERIA	0	430	0	2,106,925		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	64,250	834,278	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,224	775	0	21,152	0	14.00
15.00	01500	PHARMACY	0	607	0	69,810	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	580	0	126,916	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	16,832	1,855	0	15,611	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,040	0	18,786	18,786	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	6,629	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	303,132	16,866	15,101	186,745	186,745	30.00
31.00	03100	INTENSIVE CARE UNIT	107,189	5,150	6,445	106,458	106,458	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,639	67,313	66,075	40.00
41.00	04100	SUBPROVIDER - IRF	50,260	3,046	6,447	62,149	62,149	41.00
43.00	04300	NURSERY	2,197	177	0	8,554	8,554	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,447	3,848	0	68,365	51,885	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	23,849	1,023	0	26,320	26,320	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,438	235	0	29,215	29,215	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,066	3,201	0	104,504	10,278	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,933	0	0	62,470	44,607	55.00
60.00	06000	LABORATORY	0	971	0	97,935	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	318	730	0	63,804	0	65.00
66.00	06600	PHYSICAL THERAPY	9,347	1,853	0	107,567	36,263	66.00
69.00	06900	ELECTROCARDIOLOGY	16,576	2,821	0	89,920	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	11,990	716	0	13,518	3,446	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	30,473	3,002	0	37,816	37,816	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6	1,108	0	3,389	0	90.00
90.01	04950	WOUND CLINIC	7,574	355	0	10,744	2,928	90.01
91.00	09100	EMERGENCY	79,830	4,543	0	120,395	120,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,396	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	928	0	14,018	14,018	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	847,051	57,646	32,632	1,607,749	825,938	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,027	10,523	0	386,041	8,340	192.00
192.01	19201	FP PETERSBURG	0	0	0	8,557	0	192.01
192.02	19202	PEDIATRICS	0	0	0	31,077	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	32,114	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	0	335	0	10	0	194.00
194.01	07960	CCBHC GRANTS	0	0	0	7,958	0	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	60	0	7,863	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	25,556	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	0	194.09
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)	679,624	3,571,210	1,394,221	2,238,752	4,764,374	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.772232	52.085788	42.725576	1.062568	5.710775	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	190,686	295,244	24,480	469,220	390,096	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.216669	4.306108	0.750184	0.222704	0.467585	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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,512,601					14.00
15.00	01500	PHARMACY	60,257	20,096,839				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,405	0	70,125			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OH	3,980	0	0	0	19,250,132	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	50,055	32,680	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	3,077	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	383,474	468	14,575	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	316,343	99	7,000	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	23,448	99	7,525	0	8,730,989	40.00
41.00	04100	SUBPROVIDER - IRF	82,251	9	4,375	0	0	41.00
43.00	04300	NURSERY	19,814	62	1,200	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	632,088	23,781	5,800	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	395,663	1,630	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,534	502	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281,936	247,469	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	92,342	3,730	0	0	0	55.00
60.00	06000	LABORATORY	2,364,643	1,327	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	63,283	3,142	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	54,882	3,297	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	139,346	75,773	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	33,578	19	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,049,804	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,970,317	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,747,568	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	348,913	27,758	16,350	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	2,110	4,415	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	427	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	97,755	12,998	3,000	0	0	90.01
91.00	09100	EMERGENCY	297,220	11,538	10,300	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	54,703	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	17,781	79	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,921,429	18,198,443	70,125	0	8,730,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,916,862	1,349,368	0	0	0	192.00
192.01	19201	FP PETERSBURG	11,590	11,700	0	0	0	192.01
192.02	19202	PEDIATRICS	406,231	386,176	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	170,585	150,462	0	0	0	192.03
194.00	07950	COMMUNITY HEALTH SERVICES	2,029	0	0	0	0	194.00
194.01	07960	CCBHC GRANTS	8,502	690	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,683	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	24,710	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	48,980	0	0	0	10,519,143	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,046,693	4,771,873	6,038,134	0	1,254,635	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.063388	0.237444	86.105298	0.000000	0.065175	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	157,535	259,277	228,697	0	113,782	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009540	0.012901	3.261276	0.000000	0.005911	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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:33 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,925					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		3,925				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY			100			23.00
23.01	02301	PARAMED ED PRGM-LAB				100		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,436	1,436	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	156	156	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	944	944	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
51.01	05101	ENDOSCOPY	0	0	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	100	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	56	56	0	0		55.00
60.00	06000	LABORATORY	0	0	0	100		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	84	84	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	128	128	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	596	596	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	44	44	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	04950	WOUND CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	245	245	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,689	3,689	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	236	236	0	0		192.00
192.01	19201	FP PETERSBURG	0	0	0	0		192.01
192.02	19202	PEDIATRICS	0	0	0	0		192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0		192.03

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0		194.00
194.01	07960	CCBHC GRANTS	0	0	0	0		194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0		194.03
194.04	07954	UNUSED SPACE	0	0	0	0		194.04
194.05	07955	MOB	0	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0		194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,458,075	2,239,080	0	321,483		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	371.484076	570.466242	0.000000	3,214.830000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	365,127	31,879	0	3,560		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	93.025987	8.122038	0.000000	35.600000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:33 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,545,742		15,545,742	0	15,545,742	30.00
31.00	03100	INTENSIVE CARE UNIT	8,574,268		8,574,268	0	8,574,268	31.00
40.00	04000	SUBPROVIDER - IPF	5,213,502		5,213,502	37,066	5,250,568	40.00
41.00	04100	SUBPROVIDER - IRF	4,730,282		4,730,282	0	4,730,282	41.00
43.00	04300	NURSERY	633,822		633,822	0	633,822	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,270,081		7,270,081	38,075	7,308,156	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,685,887		2,685,887	0	2,685,887	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,787,241		1,787,241	0	1,787,241	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,690,303		9,690,303	0	9,690,303	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,059,124		5,059,124	6,863	5,065,987	55.00
60.00	06000	LABORATORY	10,618,102		10,618,102	0	10,618,102	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,843,204	0	3,843,204	0	3,843,204	65.00
66.00	06600	PHYSICAL THERAPY	6,893,126	0	6,893,126	0	6,893,126	66.00
69.00	06900	ELECTROCARDIOLOGY	5,667,228		5,667,228	5,233	5,672,461	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,236,989		1,236,989	9,560	1,246,549	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,026,112		5,026,112	0	5,026,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,013,700		5,013,700	0	5,013,700	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,294,278		24,294,278	0	24,294,278	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,330,840		4,330,840	8,716	4,339,556	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	765,250		765,250	0	765,250	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	302,401		302,401	0	302,401	90.00
90.01	04950	WOUND CLINIC	1,675,862		1,675,862	0	1,675,862	90.01
91.00	09100	EMERGENCY	9,613,534		9,613,534	0	9,613,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,722,080		2,722,080		2,722,080	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	222,228		222,228	0	222,228	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,413,035		1,413,035		1,413,035	116.00
200.00		Subtotal (see instructions)	144,828,221	0	144,828,221	105,513	144,933,734	200.00
201.00		Less Observation Beds	2,722,080		2,722,080		2,722,080	201.00
202.00		Total (see instructions)	142,106,141	0	142,106,141	105,513	142,211,654	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/29/2021 2:33 pm

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		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	25,411,336		25,411,336			30.00
31.00	03100	INTENSIVE CARE UNIT	16,111,220		16,111,220			31.00
40.00	04000	SUBPROVIDER - IPF	8,730,989		8,730,989			40.00
41.00	04100	SUBPROVIDER - IRF	7,404,201		7,404,201			41.00
43.00	04300	NURSERY	1,367,007		1,367,007			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,747,538	20,605,174	39,352,712	0.184742	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,160,799	9,398,853	10,559,652	0.254354	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,031,496	204,123	5,235,619	0.341362	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,532,436	70,662,836	85,195,272	0.113742	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	545,037	22,276,428	22,821,465	0.221683	0.000000	55.00
60.00	06000	LABORATORY	23,840,550	47,979,070	71,819,620	0.147844	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,086,916	2,768,275	13,855,191	0.277384	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,221,681	9,075,932	24,297,613	0.283696	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,470,378	23,000,821	38,471,199	0.147311	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	171,222	5,115,252	5,286,474	0.233991	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,265,245	1,951,963	4,217,208	1.191810	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,904,278	5,323,831	10,228,109	0.490188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,531,646	63,441,025	84,972,671	0.285907	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	114,163	21,233,615	21,347,778	0.202871	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	991,859	27,321	1,019,180	0.750849	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	250	93,709	93,959	3.218436	0.000000	90.00
90.01	04950	WOUND CLINIC	104,446	4,358,729	4,463,175	0.375487	0.000000	90.01
91.00	09100	EMERGENCY	10,551,708	35,246,911	45,798,619	0.209909	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,700,230	4,256,596	5,956,826	0.456968	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	422,599	422,599	0.525860	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,216,085	2,216,085			116.00
200.00		Subtotal (see instructions)	206,996,631	349,659,148	556,655,779			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	206,996,631	349,659,148	556,655,779			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:33 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
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.185709	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.254354	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221983	55.00
60.00	06000	LABORATORY	0.147844	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147447	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.235800	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.203279	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	3.218436	90.00
90.01	04950	WOUND CLINIC	0.375487	90.01
91.00	09100	EMERGENCY	0.209909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,545,742		15,545,742	0	15,545,742	30.00
31.00	03100	INTENSIVE CARE UNIT	8,574,268		8,574,268	0	8,574,268	31.00
40.00	04000	SUBPROVIDER - IPF	5,213,502		5,213,502	37,066	5,250,568	40.00
41.00	04100	SUBPROVIDER - IRF	4,730,282		4,730,282	0	4,730,282	41.00
43.00	04300	NURSERY	633,822		633,822	0	633,822	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,270,081		7,270,081	38,075	7,308,156	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,685,887		2,685,887	0	2,685,887	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,787,241		1,787,241	0	1,787,241	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,690,303		9,690,303	0	9,690,303	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,059,124		5,059,124	6,863	5,065,987	55.00
60.00	06000	LABORATORY	10,618,102		10,618,102	0	10,618,102	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,843,204	0	3,843,204	0	3,843,204	65.00
66.00	06600	PHYSICAL THERAPY	6,893,126	0	6,893,126	0	6,893,126	66.00
69.00	06900	ELECTROCARDIOLOGY	5,667,228		5,667,228	5,233	5,672,461	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,236,989		1,236,989	9,560	1,246,549	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,026,112		5,026,112	0	5,026,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,013,700		5,013,700	0	5,013,700	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,294,278		24,294,278	0	24,294,278	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,330,840		4,330,840	8,716	4,339,556	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	765,250		765,250	0	765,250	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	302,401		302,401	0	302,401	90.00
90.01	04950	WOUND CLINIC	1,675,862		1,675,862	0	1,675,862	90.01
91.00	09100	EMERGENCY	9,613,534		9,613,534	0	9,613,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,722,080		2,722,080		2,722,080	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	222,228		222,228	0	222,228	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,413,035		1,413,035		1,413,035	116.00
200.00		Subtotal (see instructions)	144,828,221	0	144,828,221	105,513	144,933,734	200.00
201.00		Less Observation Beds	2,722,080		2,722,080		2,722,080	201.00
202.00		Total (see instructions)	142,106,141	0	142,106,141	105,513	142,211,654	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,411,336		25,411,336			30.00
31.00	03100	INTENSIVE CARE UNIT	16,111,220		16,111,220			31.00
40.00	04000	SUBPROVIDER - IPF	8,730,989		8,730,989			40.00
41.00	04100	SUBPROVIDER - IRF	7,404,201		7,404,201			41.00
43.00	04300	NURSERY	1,367,007		1,367,007			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,747,538	20,605,174	39,352,712	0.184742	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,160,799	9,398,853	10,559,652	0.254354	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,031,496	204,123	5,235,619	0.341362	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,532,436	70,662,836	85,195,272	0.113742	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	545,037	22,276,428	22,821,465	0.221683	0.000000	55.00
60.00	06000	LABORATORY	23,840,550	47,979,070	71,819,620	0.147844	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,086,916	2,768,275	13,855,191	0.277384	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,221,681	9,075,932	24,297,613	0.283696	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,470,378	23,000,821	38,471,199	0.147311	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	171,222	5,115,252	5,286,474	0.233991	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,265,245	1,951,963	4,217,208	1.191810	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,904,278	5,323,831	10,228,109	0.490188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,531,646	63,441,025	84,972,671	0.285907	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	114,163	21,233,615	21,347,778	0.202871	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	991,859	27,321	1,019,180	0.750849	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	250	93,709	93,959	3.218436	0.000000	90.00
90.01	04950	WOUND CLINIC	104,446	4,358,729	4,463,175	0.375487	0.000000	90.01
91.00	09100	EMERGENCY	10,551,708	35,246,911	45,798,619	0.209909	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,700,230	4,256,596	5,956,826	0.456968	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	422,599	422,599	0.525860	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,216,085	2,216,085			116.00
200.00		Subtotal (see instructions)	206,996,631	349,659,148	556,655,779			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	206,996,631	349,659,148	556,655,779			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	04950	WOUND CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0042

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

Worksheet D Part I

Date/Time Prepared: 7/29/2021 2:33 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	2,572,436	0	2,572,436	14,603	176.16	30.00
31.00	INTENSIVE CARE UNIT	939,590		939,590	6,301	149.12	31.00
40.00	SUBPROVIDER - IPF	609,724	0	609,724	4,639	131.43	40.00
41.00	SUBPROVIDER - IRF	717,596	0	717,596	6,447	111.31	41.00
43.00	NURSERY	15,062		15,062	930	16.20	43.00
200.00	Total (lines 30 through 199)	4,854,408		4,854,408	32,920		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	6,321	1,113,507	30.00
31.00	INTENSIVE CARE UNIT	3,648	543,990	31.00
40.00	SUBPROVIDER - IPF	1,379	181,242	40.00
41.00	SUBPROVIDER - IRF	5,377	598,514	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	16,725	2,437,253	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/29/2021 2:33 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						
50.00	05000	OPERATING ROOM	998,788	39,352,712	0.025380	8,285,382	210,283	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	487,400	10,559,652	0.046157	603,148	27,840	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,169	5,235,619	0.007290	14,248	104	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,273	85,195,272	0.010814	7,516,902	81,288	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	710,561	22,821,465	0.031136	357,220	11,122	55.00
60.00	06000	LABORATORY	432,486	71,819,620	0.006022	12,547,860	75,563	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	248,636	13,855,191	0.017945	4,827,722	86,633	65.00
66.00	06600	PHYSICAL THERAPY	641,202	24,297,613	0.026390	3,718,907	98,142	66.00
69.00	06900	ELECTROCARDIOLOGY	733,616	38,471,199	0.019069	7,233,176	137,929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	291,784	5,286,474	0.055194	43,808	2,418	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,375	4,217,208	0.030678	1,162,115	35,651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,083	10,228,109	0.012718	2,585,234	32,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	378,516	84,972,671	0.004455	9,910,884	44,153	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,568	21,347,778	0.006210	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	306,887	1,019,180	0.301112	643,014	193,619	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,358	93,959	0.919103	0	0	90.00
90.01	04950	WOUND CLINIC	134,063	4,463,175	0.030038	11,663	350	90.01
91.00	09100	EMERGENCY	1,061,299	45,798,619	0.023173	5,522,642	127,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	450,436	5,956,826	0.075617	812,948	61,473	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	17,474	422,599	0.041349	0	0	96.00
200.00		Total (lines 50 through 199)	8,330,974	495,414,941		65,796,873	1,227,423	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	14,603	0.00	6,321	30.00
31.00	03100	INTENSIVE CARE UNIT		0	6,301	0.00	3,648	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,639	0.00	1,379	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	6,447	0.00	5,377	41.00
43.00	04300	NURSERY		0	930	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	32,920		16,725	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

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

Worksheet D Part IV

Date/Time Prepared: 7/29/2021 2:33 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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	321,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	321,483	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/29/2021 2:33 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						
50.00	05000	OPERATING ROOM	0	0	0	39,352,712	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,559,652	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,235,619	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	85,195,272	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	22,821,465	0.000000	55.00
60.00	06000	LABORATORY	0	321,483	321,483	71,819,620	0.004476	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,855,191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,297,613	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,471,199	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,286,474	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,217,208	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,228,109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,972,671	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	21,347,778	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,019,180	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	93,959	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	4,463,175	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	45,798,619	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,956,826	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	422,599	0.000000	96.00
200.00		Total (lines 50 through 199)	0	321,483	321,483	495,414,941		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:33 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						
50.00	05000	OPERATING ROOM	0.000000	8,285,382	0	6,751,542	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	603,148	0	3,213,977	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	14,248	0	8,491	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,516,902	0	26,417,214	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	357,220	0	11,341,006	0	55.00
60.00	06000	LABORATORY	0.004476	12,547,860	56,164	5,943,635	26,604	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,827,722	0	1,225,739	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,718,907	0	143,471	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,233,176	0	11,061,497	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	43,808	0	1,643,209	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,162,115	0	1,016,676	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,585,234	0	2,323,193	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,910,884	0	32,581,966	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	5,821,933	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	643,014	0	19,515	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	277	0	90.00
90.01	04950	WOUND CLINIC	0.000000	11,663	0	2,369,499	0	90.01
91.00	09100	EMERGENCY	0.000000	5,522,642	0	7,828,759	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	812,948	0	2,075,810	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		65,796,873	56,164	121,787,409	26,604	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.184742	6,751,542	0	0	1,247,293	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	3,213,977	0	0	817,488	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	8,491	0	0	2,899	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	26,417,214	0	0	3,004,747	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221683	11,341,006	0	0	2,514,108	55.00
60.00	06000	LABORATORY	0.147844	5,943,635	0	0	878,731	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	1,225,739	0	0	340,000	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	143,471	0	0	40,702	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147311	11,061,497	0	0	1,629,480	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233991	1,643,209	0	0	384,496	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	1,016,676	0	0	1,211,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	2,323,193	0	0	1,138,801	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	32,581,966	220	21,821	9,315,412	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202871	5,821,933	0	0	1,181,101	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	19,515	0	0	14,653	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.218436	277	0	0	892	90.00
90.01	04950	WOUND CLINIC	0.375487	2,369,499	0	0	889,716	90.01
91.00	09100	EMERGENCY	0.209909	7,828,759	0	0	1,643,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	2,075,810	0	0	948,579	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	0	0	96.00
200.00		Subtotal (see instructions)		121,787,409	220	21,821	27,204,110	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		121,787,409	220	21,821	27,204,110	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63	6,239	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	63	6,239	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	63	6,239	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | 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						
50.00	05000	OPERATING ROOM	998,788	39,352,712	0.025380	11,821	300	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	487,400	10,559,652	0.046157	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,169	5,235,619	0.007290	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,273	85,195,272	0.010814	54,755	592	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	710,561	22,821,465	0.031136	0	0	55.00
60.00	06000	LABORATORY	432,486	71,819,620	0.006022	209,228	1,260	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	248,636	13,855,191	0.017945	94,541	1,697	65.00
66.00	06600	PHYSICAL THERAPY	641,202	24,297,613	0.026390	24,225	639	66.00
69.00	06900	ELECTROCARDIOLOGY	733,616	38,471,199	0.019069	14,109	269	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	291,784	5,286,474	0.055194	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,375	4,217,208	0.030678	5,089	156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,083	10,228,109	0.012718	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	378,516	84,972,671	0.004455	313,585	1,397	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,568	21,347,778	0.006210	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	306,887	1,019,180	0.301112	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,358	93,959	0.919103	0	0	90.00
90.01	04950	WOUND CLINIC	134,063	4,463,175	0.030038	0	0	90.01
91.00	09100	EMERGENCY	1,061,299	45,798,619	0.023173	219,966	5,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,956,826	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	17,474	422,599	0.041349	0	0	96.00
200.00		Total (lines 50 through 199)	7,880,538	495,414,941		947,319	11,407	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IPF	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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	321,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	321,483	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | 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						
50.00	05000	OPERATING ROOM	0	0	0	39,352,712	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,559,652	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,235,619	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	85,195,272	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	22,821,465	0.000000	55.00
60.00	06000	LABORATORY	0	321,483	321,483	71,819,620	0.004476	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,855,191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,297,613	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,471,199	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,286,474	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,217,208	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,228,109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,972,671	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	21,347,778	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,019,180	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	93,959	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	4,463,175	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	45,798,619	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,956,826	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	422,599	0.000000	96.00
200.00		Total (lines 50 through 199)	0	321,483	321,483	495,414,941		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | 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						
50.00	05000	OPERATING ROOM	0.000000	11,821	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54,755	0	1,895	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004476	209,228	937	282	1	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	94,541	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	24,225	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,109	0	300	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,089	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	313,585	0	1,669	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	219,966	0	3,362	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		947,319	937	7,508	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | 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						
50.00	05000	OPERATING ROOM	0.184742	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	1,895	0	0	216	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221683	0	0	0	0	55.00
60.00	06000	LABORATORY	0.147844	282	0	0	42	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147311	300	0	0	44	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233991	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	1,669	0	705	477	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202871	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.218436	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.209909	3,362	0	75	706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	0	0	96.00
200.00		Subtotal (see instructions)		7,508	0	780	1,485	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		7,508	0	780	1,485	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	202	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	218	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	218	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II
Component CCN: 15-T042 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IRF | 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						
50.00	05000	OPERATING ROOM	998,788	39,352,712	0.025380	37,986	964	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	487,400	10,559,652	0.046157	23,079	1,065	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,169	5,235,619	0.007290	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,273	85,195,272	0.010814	423,416	4,579	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	710,561	22,821,465	0.031136	4,069	127	55.00
60.00	06000	LABORATORY	432,486	71,819,620	0.006022	1,001,214	6,029	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	248,636	13,855,191	0.017945	878,125	15,758	65.00
66.00	06600	PHYSICAL THERAPY	641,202	24,297,613	0.026390	7,780,416	205,325	66.00
69.00	06900	ELECTROCARDIOLOGY	733,616	38,471,199	0.019069	131,695	2,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	291,784	5,286,474	0.055194	3,960	219	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,375	4,217,208	0.030678	102,657	3,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,083	10,228,109	0.012718	1,784	23	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	378,516	84,972,671	0.004455	1,149,602	5,121	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,568	21,347,778	0.006210	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	306,887	1,019,180	0.301112	75,212	22,647	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,358	93,959	0.919103	0	0	90.00
90.01	04950	WOUND CLINIC	134,063	4,463,175	0.030038	0	0	90.01
91.00	09100	EMERGENCY	1,061,299	45,798,619	0.023173	54,138	1,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,956,826	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	17,474	422,599	0.041349	0	0	96.00
200.00		Total (lines 50 through 199)	7,880,538	495,414,941		11,667,353	268,772	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	321,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	321,483	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:33 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	39,352,712	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,559,652	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,235,619	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	85,195,272	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	22,821,465	0.000000	55.00
60.00	06000	LABORATORY	0	321,483	321,483	71,819,620	0.004476	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,855,191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,297,613	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,471,199	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,286,474	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,217,208	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,228,109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,972,671	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	21,347,778	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,019,180	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	93,959	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	4,463,175	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	45,798,619	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,956,826	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	422,599	0.000000	96.00
200.00		Total (lines 50 through 199)	0	321,483	321,483	495,414,941		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	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						
50.00	05000	OPERATING ROOM	0.000000	37,986	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	23,079	0	1	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	1	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	423,416	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	4,069	0	44	0	55.00
60.00	06000	LABORATORY	0.004476	1,001,214	4,481	290	1	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	878,125	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,780,416	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	131,695	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	3,960	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	102,657	0	113	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,784	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,149,602	0	322	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	75,212	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	54,138	0	3,042	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		11,667,353	4,481	3,813	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/29/2021 2:33 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.184742	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	1	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	1	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221683	44	0	0	10	55.00
60.00	06000	LABORATORY	0.147844	290	0	0	43	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147311	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233991	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	113	0	0	135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	322	0	488	92	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202871	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.218436	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.209909	3,042	0	0	639	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	0	0	96.00
200.00		Subtotal (see instructions)		3,813	0	488	919	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,813	0	488	919	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V

Component CCN: 15-T042 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	140	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	140	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	140	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,603	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,603	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)	12,046	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)	6,321	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)	15,545,742	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)	15,545,742	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)	15,545,742	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)	1,064.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,729,084	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)	6,729,084	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,574,268	6,301	1,360.78	3,648	4,964,125	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	15,461,159	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	27,154,368	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,657,497	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,283,587	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,941,084	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,213,284	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)	2,557	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,064.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,722,080	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 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	2,572,436	15,545,742	0.165475	2,722,080	450,436	90.00
91.00	Nursing School cost	0	15,545,742	0.000000	2,722,080	0	91.00
92.00	Allied health cost	0	15,545,742	0.000000	2,722,080	0	92.00
93.00	All other Medical Education	0	15,545,742	0.000000	2,722,080	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | 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)	4,639	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,639	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,639	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)	1,379	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)	5,250,568	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)	5,250,568	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)	5,250,568	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)	1,131.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,560,794	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)	1,560,794	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	216,427	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,777,221	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)	181,242	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,344	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	193,586	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,583,635	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: 15-0042	Period: From 01/01/2020 To 12/31/2020
Component CCN: 15-S042	Worksheet D-1 Date/Time Prepared: 7/29/2021 2:33 pm
Title XVIII	Subprovider - IPF	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	609,724	5,250,568	0.116125	0	0	90.00
91.00	Nursing School cost	0	5,250,568	0.000000	0	0	91.00
92.00	Allied health cost	0	5,250,568	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,250,568	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	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)	6,447	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,447	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)	6,447	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)	5,377	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)	4,730,282	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)	4,730,282	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)	4,730,282	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)	733.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,945,212	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,945,212	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,200,951	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,146,163	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)	598,514	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	273,253	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	871,767	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,274,396	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: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	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	717,596	4,730,282	0.151703	0	0	90.00
91.00	Nursing School cost	0	4,730,282	0.000000	0	0	91.00
92.00	Allied health cost	0	4,730,282	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,730,282	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 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)	14,603	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,603	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)	12,046	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)	363	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)	930	15.00
16.00	Nursery days (title V or XIX only)	56	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)	15,545,742	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)	15,545,742	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)	15,545,742	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)	1,064.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	386,435	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)	386,435	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 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)	633,822	930	681.53	56	38,166	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,574,268	6,301	1,360.78	62	84,368	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	550,601	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,059,570	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)	2,557	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,064.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,722,080	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 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	2,572,436	15,545,742	0.165475	2,722,080	450,436	90.00
91.00	Nursing School cost	0	15,545,742	0.000000	2,722,080	0	91.00
92.00	Allied health cost	0	15,545,742	0.000000	2,722,080	0	92.00
93.00	All other Medical Education	0	15,545,742	0.000000	2,722,080	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IPF | 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)	4,639	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,639	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,639	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)	394	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)	930	15.00
16.00	Nursery days (title V or XIX only)	56	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)	5,213,502	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)	5,213,502	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)	5,213,502	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,123.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	442,793	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	442,793	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	28,937	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	471,730	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: 15-0042 Component CCN: 15-S042	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XIX	Subprovider - IPF	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	609,724	5,213,502	0.116951	0	0	90.00
91.00	Nursing School cost	0	5,213,502	0.000000	0	0	91.00
92.00	Allied health cost	0	5,213,502	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,213,502	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IRF | 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)	6,447	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,447	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)	6,447	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)	21	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)	930	15.00
16.00	Nursery days (title V or XIX only)	56	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)	4,730,282	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)	4,730,282	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)	4,730,282	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)	733.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,408	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)	15,408	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	35,048	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	50,456	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: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IRF | 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	717,596	4,730,282	0.151703	0	0	90.00
91.00	Nursing School cost	0	4,730,282	0.000000	0	0	91.00
92.00	Allied health cost	0	4,730,282	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,730,282	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 2:33 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		11,595,640		30.00
31.00	03100	INTENSIVE CARE UNIT		9,019,748		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		69,767		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.185709	8,285,382	1,538,670	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	603,148	153,413	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	14,248	4,864	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	7,516,902	854,987	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221983	357,220	79,297	55.00
60.00	06000	LABORATORY	0.147844	12,547,860	1,855,126	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	4,827,722	1,339,133	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	3,718,907	1,055,039	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147447	7,233,176	1,066,510	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.235800	43,808	10,330	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	1,162,115	1,385,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	2,585,234	1,267,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	9,910,884	2,833,591	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.203279	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	643,014	482,806	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.218436	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	11,663	4,379	90.01
91.00	09100	EMERGENCY	0.209909	5,522,642	1,159,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	812,948	371,491	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		65,796,873	15,461,159	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)		65,796,873		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,313,220		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.185709	11,821	2,195	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	54,755	6,228	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221983	0	0	55.00
60.00	06000	LABORATORY	0.147844	209,228	30,933	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	94,541	26,224	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	24,225	6,873	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147447	14,109	2,080	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.235800	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	5,089	6,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	313,585	89,656	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.203279	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.218436	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	0	0	90.01
91.00	09100	EMERGENCY	0.209909	219,966	46,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		947,319	216,427	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)		947,319		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		6,237,319		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.185709	37,986	7,054	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	23,079	5,870	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	423,416	48,160	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221983	4,069	903	55.00
60.00	06000	LABORATORY	0.147844	1,001,214	148,023	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	878,125	243,578	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	7,780,416	2,207,273	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147447	131,695	19,418	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.235800	3,960	934	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	102,657	122,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	1,784	874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	1,149,602	328,679	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.203279	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	75,212	56,473	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.218436	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	0	0	90.01
91.00	09100	EMERGENCY	0.209909	54,138	11,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,667,353	3,200,951	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)		11,667,353		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 2:33 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		334,473		30.00
31.00	03100	INTENSIVE CARE UNIT		249,846		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		91,830		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.184742	324,267	59,906	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	18,450	4,693	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	336,080	114,725	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	259,649	29,533	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221683	10,829	2,401	55.00
60.00	06000	LABORATORY	0.147844	454,060	67,130	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	181,809	50,431	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	91,689	26,012	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147311	152,159	22,415	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233991	1,698	397	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	377,604	107,960	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202871	2,566	521	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	11,274	8,465	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.218436	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	4,852	1,822	90.01
91.00	09100	EMERGENCY	0.209909	254,471	53,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	1,694	774	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,483,151	550,601	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)		2,483,151		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XIX	Subprovider - IPF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		575,212		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.184742	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	208	53	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	16,881	1,920	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221683	0	0	55.00
60.00	06000	LABORATORY	0.147844	38,012	5,620	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	10,636	2,950	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	9,310	2,641	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147311	2,807	414	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233991	822	192	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	1,948	2,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	42,876	12,259	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202871	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	754	566	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.218436	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	0	0	90.01
91.00	09100	EMERGENCY	0.209909	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		124,254	28,937	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)		124,254		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		100,517		41.00
43.00	04300	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.184742	311	57	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.254354	806	205	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.341362	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113742	7,856	894	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.221683	0	0	55.00
60.00	06000	LABORATORY	0.147844	11,597	1,715	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277384	3,564	989	65.00
66.00	06600	PHYSICAL THERAPY	0.283696	82,521	23,411	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147311	1,497	221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233991	189	44	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.191810	2,988	3,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.490188	115	56	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285907	11,935	3,412	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202871	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.750849	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.218436	0	0	90.00
90.01	04950	WOUND CLINIC	0.375487	1,285	483	90.01
91.00	09100	EMERGENCY	0.209909	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.456968	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.525860	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		124,664	35,048	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)		124,664		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 2:33 pm
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		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)	14,203,464	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,476,774	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)	41,897	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	11,911	2.04
3.00	Managed Care Simulated Payments	4,235,401	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	90.95	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	8.14	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	8.14	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.089500	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.091905	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.089500	21.00
22.00	IME payment adjustment (see instructions)	986,241	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	201,986	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)	986,241	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	201,986	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.88	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.49	31.00
32.00	Sum of lines 30 and 31	21.37	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.84	33.00
34.00	Disproportionate share adjustment (see instructions)	353,632	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000282312	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,050,815	2,340,371	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,535,310	589,902	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,125,212		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)	24,199,131		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	25,631,657		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	25,475,512	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,668,826	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).	430,471	52.00
53.00	Nursing and Allied Health Managed Care payment	14,973	53.00
54.00	Special add-on payments for new technologies	143,296	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)	56,164	58.00
59.00	Total (sum of amounts on lines 49 through 58)	27,789,242	59.00
60.00	Primary payer payments	4,562	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	27,784,680	61.00
62.00	Deductibles billed to program beneficiaries	2,429,196	62.00
63.00	Coinsurance billed to program beneficiaries	25,696	63.00
64.00	Allowable bad debts (see instructions)	365,951	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	237,868	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	135,130	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	25,567,656	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)	-1,374	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-7,440	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-41,100	70.93
70.94	HRR adjustment amount (see instructions)	-144,910	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A | Date/Time Prepared: 7/29/2021 2:33 pm

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		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)		270,928	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		25,101,904	71.00
71.01	Sequestration adjustment (see instructions)		165,673	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		24,081,850	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)		854,381	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		570,675	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)	804,328	270,067	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0013449050	0.9909061528	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	1,082	-2,456	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9932	0.9927	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-5,469	-1,971	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/29/2021 2:33 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	14,203,464	0	14,203,464		14,203,464	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,476,774	0		6,476,774	6,476,774	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	41,897	0	41,897		41,897	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	11,911	0		11,911	11,911	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,235,401	0	3,132,889	1,102,512	4,235,401	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.089500	0.089500	0.089500	0.089500		5.00
6.00	IME payment adjustment (see instructions)	22.00	986,241	0	677,364	308,877	986,241	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	201,986	0	149,407	52,579	201,986	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	986,241	0	677,364	308,877	986,241	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	201,986	0	149,407	52,579	201,986	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0684	0.0684	0.0684	0.0684		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	353,632	0	242,879	110,753	353,632	11.00
11.01	Uncompensated care payments	36.00	2,125,212	0	1,535,310	589,902	2,125,212	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,199,131	0	16,700,914	7,498,217	24,199,131	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	25,631,657	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	25,475,512	0	17,924,716	7,550,796	25,475,512	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/29/2021 2:33 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,668,826	0	1,174,567	494,259	1,668,826	16.00
17.00	Special add-on payments for new technologies	54.00	143,296	0	0	143,296	143,296	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	19,099,283	8,188,351	27,287,634	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,574,757	0	1,107,592	467,165	1,574,757	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	20,528	0	15,251	5,277	20,528	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0467	0.0467	0.0467	0.0467		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	73,541	0	51,724	21,817	73,541	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,668,826	0	1,174,567	494,259	1,668,826	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/29/2021 2:33 pm
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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	14,203,464	14,203,464		14,203,464	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,476,774		6,476,774	6,476,774	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	41,897	41,897		41,897	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	11,911		11,911	11,911	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,235,401	3,132,889	1,102,512	4,235,401	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.089500	0.089500	0.089500		5.00
6.00	IME payment adjustment (see instructions)	22.00	986,241	677,364	308,877	986,241	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	201,986	149,407	52,579	201,986	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	986,241	677,364	308,877	986,241	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	201,986	149,407	52,579	201,986	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0684	0.0684	0.0684		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	353,632	242,879	110,753	353,632	11.00
11.01	Uncompensated care payments	36.00	2,125,212	1,535,310	589,902	2,125,212	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,199,131	16,700,914	7,498,217	24,199,131	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	25,631,657	17,522,949	8,108,708	25,631,657	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	25,475,512	17,466,848	8,008,664	25,475,512	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,668,826	1,174,567	494,259	1,668,826	16.00
17.00	Special add-on payments for new technologies	54.00	143,296	0	143,296	143,296	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			18,641,415	8,646,219	27,287,634	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,574,757	1,107,592	467,165	1,574,757	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	20,528	15,251	5,277	20,528	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0467	0.0467	0.0467		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	73,541	51,724	21,817	73,541	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,668,826	1,174,567	494,259	1,668,826	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-41,100	19,102	-60,202	-41,100	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-1,374	1,082	-2,456	-1,374	30.01
31.00	HRR adjustment (see instructions)	70.94	-144,910	-96,584	-48,326	-144,910	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-7,440	-5,469	-1,971	-7,440	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		185,595	85,333	270,928	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,302	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	27,177,506	2.00
3.00	OPPS payments	25,099,101	3.00
4.00	Outlier payment (see instructions)	35,877	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	26,604	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,302	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	22,041	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)	22,041	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)	22,041	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	15,739	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)	6,302	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)	25,161,582	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)	4,722,796	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)	20,445,088	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	324,697	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)	20,769,785	30.00
31.00	Primary payer payments	3,850	31.00
32.00	Subtotal (line 30 minus line 31)	20,765,935	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)	766,401	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	498,161	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	400,976	36.00
37.00	Subtotal (see instructions)	21,264,096	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-28	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)	21,264,124	40.00
40.01	Sequestration adjustment (see instructions)	140,343	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	20,900,870	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)	222,911	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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B
Component CCN: 15-S042 | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	218	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,484	2.00
3.00	OPPS payments	2,889	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	1	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	218	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	780	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)	780	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)	780	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	562	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)	218	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)	2,890	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)	461	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)	2,647	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)	2,647	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,647	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)	2,647	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)	2,647	40.00
40.01	Sequestration adjustment (see instructions)	17	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	2,565	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)	65	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	140	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	918	2.00
3.00	OPPS payments	820	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	1	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	140	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	488	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)	488	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)	488	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	348	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)	140	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)	821	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)	109	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)	852	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)	852	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	852	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)	852	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)	852	40.00
40.01	Sequestration adjustment (see instructions)	6	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	846	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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/29/2021 2:33 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		23,780,323		20,285,633	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	12/31/2020	243,427	12/31/2020	567,937	3.01
3.02		09/04/2020	58,100	09/04/2020	47,300	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)		301,527		615,237	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)		24,081,850		20,900,870	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		854,381		222,911	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		24,936,231		21,123,781	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | 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		996,314		2,565	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)		996,314		2,565	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		112,819		65	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,109,133		2,630	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IRF | 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		8,182,772		846	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)		8,182,772		846	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		40,781		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,223,553		846	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: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/29/2021 2:33 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: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part II | Date/Time Prepared: 7/29/2021 2:33 pm

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,199,410	1.00
2.00	Net IPF PPS Outlier Payments	23,863	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	2.58	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	2.58	8.00
9.00	Average Daily Census (see instructions)	12.674863	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.100118	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	120,083	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,343,356	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,343,356	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,343,356	18.00
19.00	Deductibles	135,080	19.00
20.00	Subtotal (line 18 minus line 19)	1,208,276	20.00
21.00	Coinsurance	102,432	21.00
22.00	Subtotal (line 20 minus line 21)	1,105,844	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,956	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	9,721	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,110	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,115,565	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	937	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,116,502	31.00
31.01	Sequestration adjustment (see instructions)	7,369	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	996,314	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	112,819	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	23,863	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,155,761	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0351	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	167,193	3.00
4.00	Outlier Payments	46,378	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	17.614754	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	8,369,332	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	8,369,332	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	8,369,332	19.00
20.00	Deductibles	87,252	20.00
21.00	Subtotal (line 19 minus line 20)	8,282,080	21.00
22.00	Coinsurance	12,936	22.00
23.00	Subtotal (line 21 minus line 22)	8,269,144	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,021	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	4,564	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,408	26.00
27.00	Subtotal (sum of lines 23 and 25)	8,273,708	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	4,481	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	8,278,189	32.00
32.01	Sequestration adjustment (see instructions)	54,636	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	8,182,772	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	40,781	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	46,378	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII Date/Time Prepared: 7/29/2021 2:33 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	1,059,570		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,059,570	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,059,570	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	676,149		8.00
9.00	Ancillary service charges	2,483,151	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	3,159,300	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	3,159,300	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,099,730	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,059,570	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,059,570	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,059,570	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,059,570	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,059,570	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,059,570	0	40.00
41.00	Interim payments	1,686,612	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-627,042	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/29/2021 2:33 pm
	Title XIX	Subprovider - IPF	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	471,730		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	471,730	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	471,730	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	575,212		8.00
9.00	Ancillary service charges	124,254	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	699,466	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	699,466	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	227,736	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	471,730	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	471,730	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	471,730	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	471,730	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	471,730	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	471,730	0	40.00
41.00	Interim payments	304,056	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	167,674	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII | Date/Time Prepared: 7/29/2021 2:33 pm

Title XIX | Subprovider - IRF | 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	50,456		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	50,456	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	50,456	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	100,512		8.00
9.00	Ancillary service charges	124,664	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	225,176	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	225,176	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	174,720	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	50,456	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	50,456	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	50,456	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	50,456	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	50,456	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	50,456	0	40.00
41.00	Interim payments	104,243	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-53,787	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.00	6.00
7.00	Enter the lesser of line 5 or line 6	0.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	6.46	4.27		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	6.46	4.27		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	6.46	4.27		17.00
18.00	Per resident amount	106,854.87	106,854.87		18.00
19.00	Approved amount for resident costs	690,282	456,270	1,146,552	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	106,854.87	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	1,146,552	25.00

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	16,725	2,939		26.00
27.00	Total Inpatient Days (see instructions)	29,543	29,543		27.00
28.00	Ratio of inpatient days to total inpatient days	0.566124	0.099482		28.00
29.00	Program direct GME amount	649,091	114,061	763,152	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		7,984	7,984	30.00
31.00	Net Program direct GME amount			755,168	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	36,077,752	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	4,562	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	36,073,190	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	27,213,174	42.00
43.00	Primary payer payments (see instructions)	3,850	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	27,209,324	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	63,282,514	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.570034	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.429966	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	755,168	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	430,471	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	324,697	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/29/2021 2:33 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	33,102,557	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	81,006,681	0	0	0	4.00
5.00	Other receivable	4,096,276	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-50,099,025	0	0	0	6.00
7.00	Inventory	3,342,820	0	0	0	7.00
8.00	Prepaid expenses	6,111,834	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	77,561,143	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,581,448	0	0	0	12.00
13.00	Land improvements	10,692,230	0	0	0	13.00
14.00	Accumulated depreciation	-6,845,015	0	0	0	14.00
15.00	Buildings	169,412,708	0	0	0	15.00
16.00	Accumulated depreciation	-78,270,314	0	0	0	16.00
17.00	Leasehold improvements	510,867	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,305,485	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	220,303,501	0	0	0	23.00
24.00	Accumulated depreciation	-153,829,892	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	170,861,018	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	97,140,693	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	5,267,433	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	102,408,126	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	350,830,287	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,211,671	0	0	0	37.00
38.00	Salaries, wages, and fees payable	15,016,211	0	0	0	38.00
39.00	Payroll taxes payable	4,124,901	0	0	0	39.00
40.00	Notes and loans payable (short term)	33,829,350	0	0	0	40.00
41.00	Deferred income	503,456	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	34,158	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	57,719,747	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	107,079,354	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	107,079,354	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	164,799,101	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	186,031,186				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)	186,031,186	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	350,830,287	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/29/2021 2:33 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		175,859,803		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,171,381				2.00
3.00	Total (sum of line 1 and line 2)		186,031,184		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	2		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)		186,031,186		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)		186,031,186		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	ROUNDING		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: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/29/2021 2:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	26,778,343		26,778,343	1.00
2.00	SUBPROVIDER - IPF	8,730,989		8,730,989	2.00
3.00	SUBPROVIDER - IRF	7,404,201		7,404,201	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)	42,913,533		42,913,533	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	16,111,220		16,111,220	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	16,111,220		16,111,220	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,024,753		59,024,753	17.00
18.00	Ancillary services	135,615,244	303,064,517	438,679,761	18.00
19.00	Outpatient services	12,356,634	43,955,945	56,312,579	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,216,085	2,216,085	26.00
27.00	DME	0	422,599	422,599	27.00
27.01	PHYSICIAN OFFICE	6,874,440	61,265,554	68,139,994	27.01
27.02	PROFESSIONAL FEES	0	9,562,546	9,562,546	27.02
27.03	DIETARY REVENUE	0	675,761	675,761	27.03
27.04	FACULTY RESIDENCY BILLINGS	0	0	0	27.04
27.05	ADMIN	0	120	120	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	213,871,071	421,163,127	635,034,198	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		243,861,743		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)		243,861,743		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/29/2021 2:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	635,034,198	1.00
2.00	Less contractual allowances and discounts on patients' accounts	414,021,254	2.00
3.00	Net patient revenues (line 1 minus line 2)	221,012,944	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	243,861,743	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-22,848,799	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	4,890,119	23.00
24.00	OTHER REVENUE	5,372,857	24.00
24.01	INVESTMENT INCOME	5,828,713	24.01
24.02	INTERCOMPANY TRANSFERS	2,661,825	24.02
24.03	OTHER NONOPERATING	1,649,415	24.03
24.50	COVID-19 PHE Funding	12,617,251	24.50
25.00	Total other income (sum of lines 6-24)	33,020,180	25.00
26.00	Total (line 5 plus line 25)	10,171,381	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,171,381	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O

Hospice CCN: 15-1526 | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	100,994	333,330	434,324	-94,002	340,322	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	2,953	2,953	0	2,953	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	2,549	2,549	0	2,549	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	79	79	0	79	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	20,751	20,751	0	20,751	26.00
27.00	NURSE PRACTITIONER**	6,406	1,372	7,778	0	7,778	27.00
28.00	REGISTERED NURSE**	191,236	40,964	232,200	0	232,200	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	76,815	16,454	93,269	0	93,269	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	34,319	7,351	41,670	0	41,670	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	29,071	6,227	35,298	0	35,298	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	438,841	432,030	870,871	-94,002	776,869	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	-27	340,295	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	2,953	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	2,549	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	79	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	20,751	26.00
27.00	NURSE PRACTITIONER**	0	7,778	27.00
28.00	REGISTERED NURSE**	0	232,200	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	93,269	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	41,670	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	35,298	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-27	776,842	100.00

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

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-2 | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	20,751	20,751	0	20,751	26.00
27.00	NURSE PRACTITIONER	5,959	1,276	7,235	0	7,235	27.00
28.00	REGISTERED NURSE	177,883	38,103	215,986	0	215,986	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	71,451	15,305	86,756	0	86,756	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	31,923	6,838	38,761	0	38,761	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	27,238	5,834	33,072	0	33,072	46.00
100.00	TOTAL *	314,454	88,107	402,561	0	402,561	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	20,751	26.00
27.00	NURSE PRACTITIONER	0	7,235	27.00
28.00	REGISTERED NURSE	0	215,986	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	86,756	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	38,761	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	33,072	46.00
100.00	TOTAL *	0	402,561	100.00

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

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-3 | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	8	2	10	0	10	27.00
28.00	REGISTERED NURSE	241	52	293	0	293	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	97	21	118	0	118	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	43	9	52	0	52	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	26	6	32	0	32	46.00
100.00	TOTAL *	415	90	505	0	505	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	10	27.00
28.00	REGISTERED NURSE	0	293	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	118	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	52	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	32	46.00
100.00	TOTAL *	0	505	100.00

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

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-4 | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	439	94	533	0	533	27.00
28.00	REGISTERED NURSE	13,112	2,809	15,921	0	15,921	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,267	1,128	6,395	0	6,395	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	2,353	504	2,857	0	2,857	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	1,807	387	2,194	0	2,194	46.00
100.00	TOTAL *	22,978	4,922	27,900	0	27,900	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	533	27.00
28.00	REGISTERED NURSE	0	15,921	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	6,395	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2,857	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2,194	46.00
100.00	TOTAL *	0	27,900	100.00

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2020 To 12/31/2020	Worksheet O-5 Date/Time Prepared: 7/29/2021 2:33 pm
		Hospice I	

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	119,799	119,799	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	523	523	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	154,949	154,949	3.00
4.00	ADMINISTRATIVE & GENERAL	340,295	114,066	454,361	4.00
5.00	PLANT OPERATION & MAINTENANCE	2,953	117,320	120,273	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	48,336	48,336	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	80,054	80,054	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,549	1,127	3,676	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	79	19	98	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	402,561		402,561	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	505		505	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	27,900		27,900	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	776,842	636,193	1,413,035	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	119,799	119,799				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	523		523			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	154,949	0	0	154,949		3.00
4.00	ADMINISTRATIVE & GENERAL	454,361	0	0	0	454,361	4.00
5.00	PLANT OPERATION & MAINTENANCE	120,273	0	0	0	120,273	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	48,336	0	0	0	48,336	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	80,054	0	0	0	80,054	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,676	0	0	0	3,676	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	98	0	0	0	98	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	402,561			144,130	546,691	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	505	11,875	52	195	12,627	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	27,900	107,924	471	10,624	146,919	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,413,035	119,799	523	154,949	1,413,035	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/29/2021 2:33 pm

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	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	454,361					4.00
5.00	PLANT OPERATION & MAINTENANCE	57,003	177,276				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	22,909	0		71,245		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	37,941	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,742	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	46	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	259,103					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,985	17,573	0	7,062	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	69,632	159,703	0	64,183	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	454,361	177,276	0	71,245	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2020 To 12/31/2020	Worksheet O-6 Part I Date/Time Prepared: 7/29/2021 2:33 pm
		Hospice I	

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	117,995					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	5,418				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	109,754	5,040	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	152	7	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	8,089	371	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	117,995	5,418	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/29/2021 2:33 pm

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	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	144					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	134	0	0		920,722	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	43,406	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	10	0	0	0	448,907	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	144	0	0	0	1,413,035	100.00

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	686					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		686				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	438,842			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-454,361	958,674	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	120,273	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	48,336	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	80,054	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	3,676	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	98	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			408,201	0	546,691	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	68	553	0	12,627	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	618	30,088	0	146,919	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	119,799	523	154,949		454,361	100.00
101.00	UNIT COST MULTIPLIER	174.634111	0.762391	0.353086		0.473947	101.00

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

Provider CCN: 15-0042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II
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	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	686					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		686			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		14,018	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					13,039	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	0	68	0	18	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	0	618	0	961	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	177,276	0	71,245	0	117,995	100.00
101.00	UNIT COST MULTIPLIER	258.419825	0.000000	103.855685	0.000000	8.417392	101.00

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/29/2021 2:33 pm

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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,557					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	5,557	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,169	0	0	0	5,169	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	0	0	0	7	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	0	0	381	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	5,418	0	0	0	144	100.00
101.00	UNIT COST MULTIPLIER	0.974987	0.000000	0.000000	0.000000	0.025913	101.00

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	5,557				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	5,169	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-7 | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.283696	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.285907	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.525860	0	0	0	5.00
6.00	LABORATORY	60.00	0.147844	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.191810	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.221683	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.750849	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-8 | Date/Time Prepared: 7/29/2021 2:33 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			920,722	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,169	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			178.12	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	4,987	30		9.00
10.00	Program cost (line 8 times line 9)	888,284	5,344		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			43,406	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			7	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			6,200.86	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	0		14.00
15.00	Program cost (line 13 times line 14)	31,004	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			448,907	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			381	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,178.23	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	326	15		19.00
20.00	Program cost (line 18 times line 19)	384,103	17,673		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,413,035	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			5,557	22.00
23.00	Average cost per diem (line 21 divided by line 22)			254.28	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,574,757	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	20,528	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)	50.43	3.00
4.00	Number of interns & residents (see instructions)	8.14	4.00
5.00	Indirect medical education percentage (see instructions)	4.67	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)	73,541	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)	1,668,826	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