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: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/29/2021 10:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/29/2021 Time: 10:15 am
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 HANCOCK REGIONAL HOSPITAL (15-0037) 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) P. JON MILLER
Officer or Administrator of Provider(s)

ASST VP FINANCE
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	287,953	-56,932	0	-132,183	1.00
2.00	Subprovider - IPF	0	6,671	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		21,647		0	10.00
200.00	Total	0	294,624	-35,285	0	-132,183	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 10:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 NORTH STATE STREET	PO Box:			1.00
2.00	City: GREENFIELD	State: IN	Zip Code: 46140-	County: HANCOCK	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	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900	4	12/01/1996	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	KNIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 10:15 am

		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.	259	543	0	0	674	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 10:15 am

		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)		23.00	1	60.01

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 10:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 10:15 am

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

		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.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
			1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N			112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		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.		2			118.00
			Premiums	Losses	Insurance	
			1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:		73,337	0	0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			Y	5.00	122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 10:15 am

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

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

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

		1.00	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: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 10:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/29/2021 10:15 am

		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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/26/2021	Y	01/26/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/29/2021 10:15 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	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.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/29/2021 10:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 10:15 am

	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	59	21,594	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)		59	21,594	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,784	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						13.00
14.00	Total (see instructions)		83	30,378	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	1,210		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	89.00				0	26.25
27.00	Total (sum of lines 14-26)		93				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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 10:15 am

	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)	895	107	3,548			1.00
2.00	HMO and other (see instructions)	1,999	1,158				2.00
3.00	HMO IPF Subprovider	123	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	895	107	3,548			7.00
8.00	INTENSIVE CARE UNIT	1,848	146	5,155			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)	2,743	253	8,703	0.00	710.44	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	476	0	555	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	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	3.98	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	266	0	3,466	0.00	3.24	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	717.66	27.00
28.00	Observation Bed Days		0	3,904			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			56			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	65	120			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 10:15 am

	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	817	53	2,330	1.00
2.00	HMO and other (see instructions)			520	324		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	817	53	2,330	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	38	0	64	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 7/29/2021 10:15 am

		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	57,848,294	-205,141	57,643,153	1,399,729.00	41.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		2,148,364	0	2,148,364	13,240.00	162.26	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		113,340	0	113,340	5,102.00	22.21	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		11,018,693	-362,071	10,656,622	195,233.00	54.58	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		73,875	0	73,875	1,525.00	48.44	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		169,159	0	169,159	1,546.00	109.42	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)		10,733,968	0	10,733,968			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,178,059	0	2,178,059			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		220,071	0	220,071			23.00
24.00	Wage-related costs (RHC/FQHC)		37,421	0	37,421			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 7/29/2021 10:15 am

		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	588,305	0	588,305	13,498.00	43.58	26.00
27.00	Administrative & General	5.00	12,489,645	-205,219	12,284,426	251,019.00	48.94	27.00
28.00	Administrative & General under contract (see inst.)		214,946	0	214,946	1,102.00	195.05	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,195,827	0	1,195,827	36,610.00	32.66	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,714,793	-7,037	1,707,756	96,531.00	17.69	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,527,824	-1,074,253	453,571	23,332.00	19.44	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,069,935	1,069,935	53,903.00	19.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,461,271	0	1,461,271	29,710.00	49.18	38.00
39.00	Central Services and Supply	14.00	197,622	0	197,622	7,663.00	25.79	39.00
40.00	Pharmacy	15.00	2,296,564	-385	2,296,179	51,006.00	45.02	40.00
41.00	Medical Records & Medical Records Library	16.00	584,363	-1,029	583,334	21,564.00	27.05	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 7/29/2021 10:15 am

		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)		55,801,536	-205,141	55,596,395	1,382,489.00	40.21	1.00
2.00	Excluded area salaries (see instructions)		11,018,693	-362,071	10,656,622	195,233.00	54.58	2.00
3.00	Subtotal salaries (line 1 minus line 2)		44,782,843	156,930	44,939,773	1,187,256.00	37.85	3.00
4.00	Subtotal other wages & related costs (see inst.)		243,034	0	243,034	3,071.00	79.14	4.00
5.00	Subtotal wage-related costs (see inst.)		10,733,968	0	10,733,968	0.00	23.89	5.00
6.00	Total (sum of lines 3 thru 5)		55,759,845	156,930	55,916,775	1,190,327.00	46.98	6.00
7.00	Total overhead cost (see instructions)		22,271,160	-217,988	22,053,172	585,938.00	37.64	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 7/29/2021 10:15 am

		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)	2,562,193	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)	6,070,949	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	436,845	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	14,586	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)	58,026	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	19,061	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	3,741,441	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	112,274	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	69,489	22.00
23.00	Tuition Reimbursement	84,655	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,169,519	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V Date/Time Prepared: 7/29/2021 10:15 am

	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	73,875	13,169,519	1.00
2.00	Hospital	73,875	13,169,519	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	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	0	0	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 RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/29/2021 10:15 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			224 WEST MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN		IN	46148	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		137632		07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HANCOCK				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0037
Component CCN: 15-3987

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

Worksheet S-8

Date/Time Prepared:
7/29/2021 10:15 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	14:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/29/2021 10:15 am

		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)	0.274805	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,957,580	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	48,211,159	6.00
7.00	Medicaid cost (line 1 times line 6)	13,248,668	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)	5,291,088	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)	5,291,088	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)	4,817,629	1,355,765	6,173,394	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,323,909	1,355,765	2,679,674	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,323,909	1,355,765	2,679,674	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)	5,400,601	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	118,493	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	182,297	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,218,304	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,497,820	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,177,494	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,468,582	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		15,292,028	15,292,028	0	15,292,028	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	588,305	9,646,618	10,234,923	0	10,234,923	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,489,645	20,831,728	33,321,373	-1,471,994	31,849,379	5.00
7.00	00700	OPERATION OF PLANT	1,195,827	5,498,528	6,694,355	942	6,695,297	7.00
9.00	00900	HOUSEKEEPING	1,714,793	868,890	2,583,683	0	2,583,683	9.00
10.00	01000	DIETARY	1,527,824	1,211,670	2,739,494	-1,918,468	821,026	10.00
11.00	01100	CAFETERIA	0	0	0	1,918,468	1,918,468	11.00
13.00	01300	NURSING ADMINISTRATION	1,461,271	344,736	1,806,007	0	1,806,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	197,622	81,767	279,389	0	279,389	14.00
15.00	01500	PHARMACY	2,296,564	15,865,828	18,162,392	-14,857,407	3,304,985	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	584,363	160,601	744,964	3,062	748,026	16.00
23.00	02300	PARAMED ED PRGM	92,598	15,143	107,741	0	107,741	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,036,278	925,814	3,962,092	508,695	4,470,787	30.00
31.00	03100	INTENSIVE CARE UNIT	3,812,757	917,066	4,729,823	-33,826	4,695,997	31.00
40.00	04000	SUBPROVIDER - IPF	422,938	117,139	540,077	-446	539,631	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,468,996	3,855,865	7,324,861	-12,786	7,312,075	50.00
51.00	05100	RECOVERY ROOM	316,579	57,071	373,650	-954	372,696	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,509,200	2,227,454	5,736,654	-194,070	5,542,584	54.00
60.00	06000	LABORATORY	1,765,596	3,990,103	5,755,699	-601	5,755,098	60.00
65.00	06500	RESPIRATORY THERAPY	1,537,500	344,888	1,882,388	1,795	1,884,183	65.00
66.00	06600	PHYSICAL THERAPY	1,094,004	184,847	1,278,851	-827	1,278,024	66.00
67.00	06700	OCCUPATIONAL THERAPY	319,936	32,437	352,373	0	352,373	67.00
68.00	06800	SPEECH PATHOLOGY	147,071	16,628	163,699	0	163,699	68.00
69.00	06900	ELECTROCARDIOLOGY	570,563	878,322	1,448,885	-26,408	1,422,477	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	175	175	-72	103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,190,292	2,190,292	0	2,190,292	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,690,587	15,690,587	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	59,313	9,958	69,271	0	69,271	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	254,537	239,139	493,676	-30,907	462,769	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	478,236	655,045	1,133,281	-14,347	1,118,934	90.01
90.02	09002	DIABETES CLINIC	27,482	7,728	35,210	0	35,210	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	95,949	55,502	151,451	-93	151,358	90.04
90.05	09005	PRIME TIME	0	36,624	36,624	0	36,624	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	30,680	3,244	33,924	0	33,924	90.06
90.07	04951	ONCOLOGY	1,202,968	1,001,896	2,204,864	-10,678	2,194,186	90.07
90.08	04950	ANDERSON WOMENS CENTER	337,261	116,552	453,813	-178	453,635	90.08
91.00	09100	EMERGENCY	2,708,481	916,419	3,624,900	-33,537	3,591,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	805,379	89,700	895,079	-895,079	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,150,516	88,687,445	136,837,961	-1,379,129	135,458,832	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	186,881	186,881	-9,017	177,864	190.01
190.02	19002	PHYSICIAN BUILDING	0	46,081	46,081	0	46,081	190.02
190.03	19003	PRIVATE DUTY	288,341	697,210	985,551	0	985,551	190.03
190.04	19004	MARKETING	0	0	0	1,470,803	1,470,803	190.04
190.05	19005	SPORTS PHYSICALS	139,338	16,368	155,706	0	155,706	190.05
190.06	19006	FOUNDATION	229,854	853,758	1,083,612	0	1,083,612	190.06
190.07	19007	ASC	0	5,329	5,329	0	5,329	190.07
190.08	19008	OTHER NONREIMBURSABLE	2,410,907	34,865	2,445,772	-11,844	2,433,928	190.08
190.09	19009	HANCOCK OB	3,232,957	1,781,623	5,014,580	-350,003	4,664,577	190.09
190.10	19010	HANCOCK WELLNESS	740,228	331,823	1,072,051	0	1,072,051	190.10
190.11	19011	MORRISTOWN CLINIC	0	600	600	0	600	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	648,244	326,205	974,449	0	974,449	190.13
190.14	19014	3 WEST UNIT	206,680	210,805	417,485	0	417,485	190.14
190.15	19015	NEUROLOGY PHYSICIAN	781,349	392,351	1,173,700	-67,443	1,106,257	190.15
190.16	19016	THORACI	18,236	22,341	40,577	0	40,577	190.16
190.17	19017	HANCOCK ENDO	412,355	259,622	671,977	-17,130	654,847	190.17
190.18	19018	HANCOCK FOOT & ANKLE	518,357	238,609	756,966	-1,062	755,904	190.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 10:15 am

		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	
190.19	19019	HANCOCK RHEUM	70,932	26,245	97,177	0	97,177	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	1,225	1,225	0	1,225	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	364,825	364,825	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	57,848,294	94,119,386	151,967,680	0	151,967,680	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,200,902	14,091,126		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,558,293	5,676,630		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,696,227	22,153,152		5.00
7.00	00700	OPERATION OF PLANT	-26,005	6,669,292		7.00
9.00	00900	HOUSEKEEPING	-162,219	2,421,464		9.00
10.00	01000	DIETARY	-872,790	-51,764		10.00
11.00	01100	CAFETERIA	-638,478	1,279,990		11.00
13.00	01300	NURSING ADMINISTRATION	-5,688	1,800,319		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-23,109	256,280		14.00
15.00	01500	PHARMACY	-1,028,029	2,276,956		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-53,947	694,079		16.00
23.00	02300	PARAMED ED PRGM	-74,334	33,407		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-157,536	4,313,251		30.00
31.00	03100	INTENSIVE CARE UNIT	-537	4,695,460		31.00
40.00	04000	SUBPROVIDER - IPF	-56,000	483,631		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,666,370	4,645,705		50.00
51.00	05100	RECOVERY ROOM	0	372,696		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-113,723	5,428,861		54.00
60.00	06000	LABORATORY	-586,140	5,168,958		60.00
65.00	06500	RESPIRATORY THERAPY	-81,616	1,802,567		65.00
66.00	06600	PHYSICAL THERAPY	0	1,278,024		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	352,373		67.00
68.00	06800	SPEECH PATHOLOGY	0	163,699		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,422,477		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,190,292		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,690,587		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	69,271		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	462,769		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-348,978	769,956		90.01
90.02	09002	DIABETES CLINIC	-490	34,720		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	-44	151,314		90.04
90.05	09005	PRIME TIME	0	36,624		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	-714	33,210		90.06
90.07	04951	ONCOLOGY	-683,101	1,511,085		90.07
90.08	04950	ANDERSON WOMENS CENTER	-45	453,590		90.08
91.00	09100	EMERGENCY	-183,653	3,407,710		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-23,218,968	112,239,864		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	177,864		190.01
190.02	19002	PHYSICIAN BUILDING	0	46,081		190.02
190.03	19003	PRIVATE DUTY	0	985,551		190.03
190.04	19004	MARKETING	0	1,470,803		190.04
190.05	19005	SPORTS PHYSICALS	0	155,706		190.05
190.06	19006	FOUNDATION	0	1,083,612		190.06
190.07	19007	ASC	0	5,329		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	2,433,928		190.08
190.09	19009	HANCOCK OB	0	4,664,577		190.09
190.10	19010	HANCOCK WELLNESS	0	1,072,051		190.10
190.11	19011	MORRISTOWN CLINIC	0	600		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	974,449		190.13
190.14	19014	3 WEST UNIT	0	417,485		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,106,257		190.15
190.16	19016	THORACI	0	40,577		190.16
190.17	19017	HANCOCK ENDO	0	654,847		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	755,904		190.18
190.19	19019	HANCOCK RHEUM	0	97,177		190.19

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.00	07950	OTHER NONREIMBURSABLE	0	1,225		194.00
194.01	07951	SUBURBAN HOSPICE	0	364,825		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-23,218,968	128,748,712		200.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/29/2021 10:15 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	1,069,935	848,533		1.00
	TOTALS		1,069,935	848,533		
	B - PLANT RECLASS					
1.00	OPERATION OF PLANT	7.00	0	942		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,062		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	3,012		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,001		4.00
	TOTALS		0	9,017		
	C - MARKETING RECLASS					
1.00	MARKETING	190.04	159,416	1,311,387		1.00
	TOTALS		159,416	1,311,387		
	E - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,690,587		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
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
	TOTALS		0	15,690,587		
	F - TERM ETO BENEFIT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,803		1.00
2.00	HOUSEKEEPING	9.00	0	7,037		2.00
3.00	DIETARY	10.00	0	4,318		3.00
4.00	PHARMACY	15.00	0	385		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,029		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	12,743		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	25,422		7.00
8.00	SUBPROVIDER - IPF	40.00	0	31,191		8.00
9.00	OPERATING ROOM	50.00	0	11,766		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,246		10.00
11.00	LABORATORY	60.00	0	13,378		11.00
12.00	RESPIRATORY THERAPY	65.00	0	5,046		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	8,943		13.00
14.00	WOUND CLINIC	90.01	0	1,800		14.00
15.00	ONCOLOGY	90.07	0	4,019		15.00
16.00	ANDERSON WOMENS CENTER	90.08	0	1,288		16.00
17.00	EMERGENCY	91.00	0	6,161		17.00
18.00	ADULTS & PEDIATRICS	30.00	0	4,444		18.00
19.00	OTHER NONREIMBURSABLE	190.08	0	3,097		19.00
20.00	HANCOCK OB	190.09	0	391		20.00
21.00	HANCOCK WELLNESS	190.10	0	4,928		21.00
22.00	MCCORD WELLNESS	190.13	0	1,065		22.00
23.00	NEUROLOGY PHYSICIAN	190.15	0	1,202		23.00
24.00	HANCOCK FOOT & ANKLE	190.18	0	1,350		24.00
25.00	SUBURBAN HOSPICE	194.01	0	3,089		25.00
	TOTALS		0	205,141		
	G - TRANSITIONS UNIT RECLASS					
1.00		0.00	0	0		1.00
8.00	ADULTS & PEDIATRICS	30.00	475,174	52,923		8.00
9.00	SUBURBAN HOSPICE	194.01	330,205	36,777		9.00
	TOTALS		805,379	89,700		
500.00	Grand Total: Increases		2,034,730	18,154,365		500.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/29/2021 10:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	1,069,935	848,533	0		1.00
	TOTALS		1,069,935	848,533			
	B - PLANT RECLASS						
1.00	PROFESSIONAL BUILDING	190.01	0	9,017	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	9,017			
	C - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	159,416	1,311,387	0		1.00
	TOTALS		159,416	1,311,387			
	E - DRUG RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,191	0		1.00
2.00	PHARMACY	15.00	0	14,857,407	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	16,298	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	33,826	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	446	0		5.00
6.00	OPERATING ROOM	50.00	0	12,786	0		6.00
7.00	RECOVERY ROOM	51.00	0	954	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	194,070	0		8.00
9.00	LABORATORY	60.00	0	601	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	206	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	827	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	29,420	0		12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	72	0		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	30,907	0		14.00
15.00	WOUND CLINIC	90.01	0	14,347	0		15.00
16.00	ANDIS CLINIC	90.04	0	93	0		16.00
18.00	ONCOLOGY	90.07	0	10,678	0		18.00
19.00	ANDERSON WOMENS CENTER	90.08	0	178	0		19.00
20.00	EMERGENCY	91.00	0	33,537	0		20.00
21.00	ADULTS & PEDIATRICS	30.00	0	3,104	0		21.00
22.00	OTHER NONREIMBURSABLE	190.08	0	11,844	0		22.00
23.00	HANCOCK OB	190.09	0	350,003	0		23.00
24.00	NEUROLOGY PHYSICIAN	190.15	0	67,443	0		24.00
25.00	HANCOCK ENDO	190.17	0	17,130	0		25.00
26.00	HANCOCK FOOT & ANKLE	190.18	0	1,062	0		26.00
27.00	SUBURBAN HOSPICE	194.01	0	2,157	0		27.00
	TOTALS		0	15,690,587			
	F - TERM ETO BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	45,803	0	0		1.00
2.00	HOUSEKEEPING	9.00	7,037	0	0		2.00
3.00	DIETARY	10.00	4,318	0	0		3.00
4.00	PHARMACY	15.00	385	0	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	1,029	0	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	12,743	0	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	25,422	0	0		7.00
8.00	SUBPROVIDER - IPF	40.00	31,191	0	0		8.00
9.00	OPERATING ROOM	50.00	11,766	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	5,246	0	0		10.00
11.00	LABORATORY	60.00	13,378	0	0		11.00
12.00	RESPIRATORY THERAPY	65.00	5,046	0	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	8,943	0	0		13.00
14.00	WOUND CLINIC	90.01	1,800	0	0		14.00
15.00	ONCOLOGY	90.07	4,019	0	0		15.00
16.00	ANDERSON WOMENS CENTER	90.08	1,288	0	0		16.00
17.00	EMERGENCY	91.00	6,161	0	0		17.00
18.00	ADULTS & PEDIATRICS	30.00	4,444	0	0		18.00
19.00	OTHER NONREIMBURSABLE	190.08	3,097	0	0		19.00
20.00	HANCOCK OB	190.09	391	0	0		20.00
21.00	HANCOCK WELLNESS	190.10	4,928	0	0		21.00
22.00	MCCORD WELLNESS	190.13	1,065	0	0		22.00
23.00	NEUROLOGY PHYSICIAN	190.15	1,202	0	0		23.00
24.00	HANCOCK FOOT & ANKLE	190.18	1,350	0	0		24.00
25.00	SUBURBAN HOSPICE	194.01	3,089	0	0		25.00
	TOTALS		205,141	0			
	G - TRANSITIONS UNIT RECLASS						
1.00		0.00	0	0	0		1.00
8.00	HOSPICE	116.00	805,379	89,700	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		805,379	89,700			
500.00	Grand Total: Decreases		2,239,871	17,949,224			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/29/2021 10:15 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,630,507	864,157	0	864,157	0	1.00
2.00	Land Improvements	14,610,715	7,393,023	0	7,393,023	0	2.00
3.00	Buildings and Fixtures	130,716,419	31,904,372	0	31,904,372	0	3.00
4.00	Building Improvements	235,570	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	86,424,406	7,327,182	0	7,327,182	87,570	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	233,617,617	47,488,734	0	47,488,734	87,570	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	233,617,617	47,488,734	0	47,488,734	87,570	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,494,664	0	1.00
2.00	Land Improvements	22,003,738	0	2.00
3.00	Buildings and Fixtures	162,620,791	0	3.00
4.00	Building Improvements	235,570	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	93,664,018	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	281,018,781	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	281,018,781	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/29/2021 10:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	15,292,028	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	15,292,028	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	15,292,028		1.00
3.00	Total (sum of lines 1-2)	0	15,292,028		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III | Date/Time Prepared: 7/29/2021 10:15 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	162,620,791	0	162,620,791	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	162,620,791	0	162,620,791	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	15,292,028	-1,197,986	1.00
3.00	Total (sum of lines 1-2)	0	0	0	15,292,028	-1,197,986	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-2,916	0	0	0	14,091,126	1.00
3.00	Total (sum of lines 1-2)	-2,916	0	0	0	14,091,126	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 10:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,861,526			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	-619,669	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 10:15 am

	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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHARMACY - MISCELLANEOUS REVENUE	B	0		0.00	0	33.00
33.01	OTHER NON-DEPARTMENTAL - MISCELLANEO	B	0		0.00	0	33.01
33.02	INTERCOMPANY REVENUE	B	0		0.00	0	33.02
33.03	ADMINISTRATION MISCELLANEOUS EXPENSE	A	0		0.00	0	33.03
33.04	DONATIONS	A	0		0.00	0	33.04
33.05	INTEREST EXPENSE	A	0		0.00	0	33.05
33.06	LOBBYING % OF DUES	A	0		0.00	0	33.06
33.07	ADMINISTRATION LEGAL FEES	A	0		0.00	0	33.07
33.08	ADMINISTRATION - CONSULTING	A	0		0.00	0	33.08
33.09	HRH MMO RENTAL INCOME	B	-160,308	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.09
33.10	HRH HUMAN RESOURCES MISCELLANEOUS RE	B	-147,400	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	HRH OTHER REVENUE SALES TAX	B	-6,965	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-120	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH ACCT ACCRUALS MISCELLANEOUS REVE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH MED STAFF SERV QA APPLICATION FE	B	-15,500	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH MED STAFF SERV MISCELLANEOUS REV	B	-7,644	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-35,000	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-2,208	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH INFO SERVICES MISCELLANEOUS REVE	B	-186,725	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH HPN IT DEPT MISCELLANEOUS REVENU	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-77,374	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	HRH ACCOUNTING MANAGEMENT FEES	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-22,082	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HRH PURCHASING MISCELLANEOUS REVENUE	B	-451	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	HRH COMMUNICATIONS MISCELLANEOUS REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-158,168	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	HRH COMM EDUCATION EDUCATION SERVICE	B	-3,126	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	HRH COMM EDUCATION CAR SEAT STATE FU	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	HRH TOBACCO AWARENE EDUCATION SERVIC	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	HRH HEALTHY 365 MISCELLANEOUS REVENU	B	-5,000	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	5,935	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	HRH PLANT OFFSITE SERVICES	B	-11,654	OPERATION OF PLANT	7.00	0	33.31
33.32	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-160,592	HOUSEKEEPING	9.00	0	33.32
33.33	HRH NUTRITIONAL SER LTACH REVENUE	B	-87,039	DIETARY	10.00	0	33.33
33.34	HRH NUTRITIONAL SER MISCELLANEOUS RE	B	0	DIETARY	10.00	0	33.34

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 10:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.35	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-1,514	DIETARY	10.00	0	33.35
33.36	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-5,568	NURSING ADMINISTRATION	13.00	0	33.36
33.37	HRH CLINICAL EDUCAT EDUCATION SERVIC	B	-60	NURSING ADMINISTRATION	13.00	0	33.37
33.38	HRH OTHER REVENUE REBATES/REFUNDS	B	-23,099	CENTRAL SERVICES & SUPPLY	14.00	0	33.38
33.39	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-10	CENTRAL SERVICES & SUPPLY	14.00	0	33.39
33.40	HRH PHARMACY MISCELLANEOUS REVENUE	B	-400	PHARMACY	15.00	0	33.40
33.41	HRH PHARMACY REBATES/REFUNDS	B	-26,259	PHARMACY	15.00	0	33.41
33.42	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-800,648	PHARMACY	15.00	0	33.42
33.43	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-171,093	PHARMACY	15.00	0	33.43
33.44	HRH ASSOCIATE PHARM PHARMACY MEDS TO	B	-4,600	PHARMACY	15.00	0	33.44
33.45	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-25,029	PHARMACY	15.00	0	33.45
33.46	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-3,551	MEDICAL RECORDS & LIBRARY	16.00	0	33.46
33.47	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-50,396	MEDICAL RECORDS & LIBRARY	16.00	0	33.47
33.48	HRH X-RAY SCHOOL TUITION-X-RAY SCHOO	B	-74,334	PARAMED ED PRGM	23.00	0	33.48
33.49	HRH MED/SURG-3 WEST MISCELLANEOUS RE	B	-21,187	ADULTS & PEDIATRICS	30.00	0	33.49
33.50	HRH ANDIS UNIT REBATES/REFUNDS	B	-1,004	ADULTS & PEDIATRICS	30.00	0	33.50
33.51	HRH SURGERY REBATES/REFUNDS	B	-734	OPERATING ROOM	50.00	0	33.51
33.52	HRH OTHER REVENUE SALE OF USED EQUIP	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.52
33.53	HRH MMO EXPENSE REIMBURSEMENT	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.53
33.54	HRH LAB WATER TESTING	B	-70,260	LABORATORY	60.00	0	33.54
33.55	HRH LAB DIRECT TESTS	B	-34,300	LABORATORY	60.00	0	33.55
33.56	HRH LAB MISCELLANEOUS REVENUE	B	-387,830	LABORATORY	60.00	0	33.56
33.57	HRH WATER LAB WATER TESTING	B	0	LABORATORY	60.00	0	33.57
33.58	HRH SLEEP STUDY CLINIC MANAGMENT	B	-66,330	RESPIRATORY THERAPY	65.00	0	33.58
33.59	HRH SLEEP STUDY SLEEP STUDY FEES	B	0	RESPIRATORY THERAPY	65.00	0	33.59
33.60	HRH CATH LAB REBATES/REFUNDS	B	0	ELECTROCARDIOLOGY	69.00	0	33.60
33.61	HRH MED ONCOLOGY MISCELLANEOUS REVEN	B	-2,120	ONCOLOGY	90.07	0	33.61
33.62	HRH E R REBATES/REFUNDS	B	-320	EMERGENCY	91.00	0	33.62
33.63	HRH HOSPICE MISCELLANEOUS REVENUE	B	0	HOSPICE	116.00	0	33.63
33.64	MOW	A	-777,896	DIETARY	10.00	0	33.64
33.65	CAFETERIA GUEST MEALS	A	-18,809	CAFETERIA	11.00	0	33.65
33.66	PHYSICIAN RECRUITMENT FEES	A	-46,500	ADMINISTRATIVE & GENERAL	5.00	0	33.66
33.67	DONATIONS & SPONSORSHIPS	A	-138,344	ADMINISTRATIVE & GENERAL	5.00	0	33.67
33.68	ADVERTISING FEE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.68
33.69	ADVERTISING FEE	A	-79,437	ADMINISTRATIVE & GENERAL	5.00	0	33.69
33.70	ADVERTISING FEE	A	-747,980	ADMINISTRATIVE & GENERAL	5.00	0	33.70
33.71	ADVERTISING FEE	A	-3,884	ADULTS & PEDIATRICS	30.00	0	33.71
33.72	ADVERTISING FEE	A	-100	OPERATING ROOM	50.00	0	33.72
33.73	ADVERTISING FEE	A	-533	RADIOLOGY-DIAGNOSTIC	54.00	0	33.73
33.74	ADVERTISING FEE	A	-2,413	WOUND CLINIC	90.01	0	33.74
33.75	ADVERTISING FEE	A	-714	SHELBYVILLE WOUND CLINIC	90.06	0	33.75
33.76	ADVERTISING FEE	A	0	HOSPICE	116.00	0	33.76
33.77	IHA LOBBYING EXPENSE	A	-3,077	ADMINISTRATIVE & GENERAL	5.00	0	33.77
33.78	AHA LOBBYING EXPENSE	A	-6,728	ADMINISTRATIVE & GENERAL	5.00	0	33.78
33.79	PHY OFFICE BLDG	A	-946,503	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.79
33.80	PHY OFFICE BLDG	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.80
33.81	PHY OFFICE BLDG	A	0	RURAL HEALTH CLINIC	88.00	0	33.81

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 10:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.82	INTEREST REVENUE	B	-2,916	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.82
33.83	RENTAL PROPERTIES EXPENSE	A	-91,175	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.83
33.84	RENTAL PROPERTIES EXPENSE	A	-187,663	ADMINISTRATIVE & GENERAL	5.00	0	33.84
33.85	RENTAL PROPERTIES EXPENSE	A	-1,975	OPERATION OF PLANT	7.00	0	33.85
33.86	RENTAL PROPERTIES EXPENSE	A	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.86
33.87	TELEPHONE SERVICES	A	-61,233	ADMINISTRATIVE & GENERAL	5.00	0	33.87
33.88	HAF EXPENSE	A	-6,246,696	ADMINISTRATIVE & GENERAL	5.00	0	33.88
33.89	SELF INSURANCE CLAIM EXPENSE	A	-4,410,893	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.89
33.90	CLINICAL EDUCATION SERVICE REVENUE	B	-60	NURSING ADMINISTRATION	13.00	0	33.90
33.91	3N MISCELLANEOUS REVENUE	B	-19,536	ADULTS & PEDIATRICS	30.00	0	33.91
33.92	CCU MISCELLANEOUS REVENUE	B	-537	INTENSIVE CARE UNIT	31.00	0	33.92
33.93	SLEEP STUDY MISCELLANEOUS REVENUE	B	-15,286	RESPIRATORY THERAPY	65.00	0	33.93
33.94	ULTRASOUND MISCELLANEOUS REVENUE	B	-6,550	RADIOLOGY-DIAGNOSTIC	54.00	0	33.94
33.95	CT SCAN MISCELLANEOUS REVENUE	B	-5,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.95
33.96	PIC AHN MISCELLANEOUS REVENUE	B	-390	RADIOLOGY-DIAGNOSTIC	54.00	0	33.96
33.97	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.97
33.98	HHA MISC REVENUE	B	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.98
33.99	NUTRITIONAL SER CAFE SALAD ROBOT	B	-6,341	DIETARY	10.00	0	33.99
34.00	PLANT MISCELLANEOUS REVENUE	B	-12,376	OPERATION OF PLANT	7.00	0	34.00
34.01	HOUSEKEEPING MISCELLANEOUS REVENUE	B	-1,627	HOUSEKEEPING	9.00	0	34.01
34.02	PAT FIN SERV EXPENSE REIMBURSEMENT	B	-38,315	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03	PURCHASING REBATES AND REFUNDS	B	-1,815	ADMINISTRATIVE & GENERAL	5.00	0	34.03
34.04	HIFI MISCELLANEOUS REVENUE	B	-600	ADMINISTRATIVE & GENERAL	5.00	0	34.04
34.05	COMM EDUCATION MISCELLANEOUS REVENUE	B	-1,665	ADMINISTRATIVE & GENERAL	5.00	0	34.05
34.06	ADVERTISING FEE	B	-44	ANDIS CLINIC	90.04	0	34.06
34.07	ADVERTISING FEE	B	-45	ANDERSON WOMENS CENTER	90.08	0	34.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-23,218,968				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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/29/2021 10:15 am

	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	1,621,696	1,621,696	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	111,925	111,925	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	56,000	56,000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,532,038	2,532,038	0	0	0	4.00
5.00	50.00	OPERATING ROOM	133,498	133,498	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	101,250	101,250	0	0	0	6.00
7.00	60.00	LABORATORY	125,000	93,750	31,250	211,500	464	7.00
8.00	90.01	WOUND CLINIC	346,565	346,565	0	0	0	8.00
9.00	90.02	DIABETES CLINIC	490	490	0	0	0	9.00
10.00	90.07	ONCOLOGY	680,981	680,981	0	0	0	10.00
11.00	91.00	EMERGENCY	183,333	183,333	0	0	0	11.00
200.00			5,892,776	5,861,526	31,250		464	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	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	47,181	2,359	0	0	0	7.00
8.00	90.01	WOUND CLINIC	0	0	0	0	0	8.00
9.00	90.02	DIABETES CLINIC	0	0	0	0	0	9.00
10.00	90.07	ONCOLOGY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			47,181	2,359	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	0	0	1,621,696		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	111,925		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	56,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	2,532,038		4.00
5.00	50.00	OPERATING ROOM	0	0	0	133,498		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	101,250		6.00
7.00	60.00	LABORATORY	0	47,181	0	93,750		7.00
8.00	90.01	WOUND CLINIC	0	0	0	346,565		8.00
9.00	90.02	DIABETES CLINIC	0	0	0	490		9.00
10.00	90.07	ONCOLOGY	0	0	0	680,981		10.00
11.00	91.00	EMERGENCY	0	0	0	183,333		11.00
200.00			0	47,181	0	5,861,526		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	14,091,126	14,091,126				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,676,630	72,468	5,749,098			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,153,152	1,219,875	1,237,852	24,610,879	24,610,879	5.00
7.00	00700	OPERATION OF PLANT	6,669,292	5,299,153	120,496	12,088,941	2,856,979	7.00
9.00	00900	HOUSEKEEPING	2,421,464	29,791	172,080	2,623,335	619,973	9.00
10.00	01000	DIETARY	-51,764	276,297	45,704	270,237	63,865	10.00
11.00	01100	CAFETERIA	1,279,990	0	107,811	1,387,801	327,979	11.00
13.00	01300	NURSING ADMINISTRATION	1,800,319	0	147,244	1,947,563	460,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	256,280	110,668	19,913	386,861	91,427	14.00
15.00	01500	PHARMACY	2,276,956	215,682	231,372	2,724,010	643,765	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	694,079	52,952	58,779	805,810	190,437	16.00
23.00	02300	PARAMED ED PRGM	33,407	27,237	9,331	69,975	16,537	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,313,251	824,472	352,096	5,489,819	1,297,409	30.00
31.00	03100	INTENSIVE CARE UNIT	4,695,460	655,341	381,627	5,732,428	1,354,745	31.00
40.00	04000	SUBPROVIDER - IPF	483,631	178,487	39,474	701,592	165,807	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,645,705	377,035	348,364	5,371,104	1,269,353	50.00
51.00	05100	RECOVERY ROOM	372,696	99,705	31,900	504,301	119,181	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,428,861	734,181	353,072	6,516,114	1,539,953	54.00
60.00	06000	LABORATORY	5,168,958	155,727	176,560	5,501,245	1,300,109	60.00
65.00	06500	RESPIRATORY THERAPY	1,802,567	162,386	154,416	2,119,369	500,870	65.00
66.00	06600	PHYSICAL THERAPY	1,278,024	138,823	110,236	1,527,083	360,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	352,373	0	32,238	384,611	90,895	67.00
68.00	06800	SPEECH PATHOLOGY	163,699	0	14,819	178,518	42,189	68.00
69.00	06900	ELECTROCARDIOLOGY	1,422,477	132,681	56,591	1,611,749	380,905	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103	0	0	103	24	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,190,292	0	0	2,190,292	517,632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,690,587	0	0	15,690,587	3,708,141	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	69,271	35,789	5,977	111,037	26,241	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	462,769	0	25,648	488,417	115,428	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	769,956	96,174	48,008	914,138	216,038	90.01
90.02	09002	DIABETES CLINIC	34,720	0	2,769	37,489	8,860	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	151,314	128,692	9,668	289,674	68,459	90.04
90.05	09005	PRIME TIME	36,624	0	0	36,624	8,655	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	33,210	0	3,091	36,301	8,579	90.06
90.07	04951	ONCOLOGY	1,511,085	423,529	120,811	2,055,425	485,759	90.07
90.08	04950	ANDERSON WOMENS CENTER	453,590	2,554	33,854	489,998	115,801	90.08
91.00	09100	EMERGENCY	3,407,710	451,541	272,297	4,131,548	976,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,239,864	11,901,240	4,724,098	109,024,978	19,949,568	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	177,864	782,254	0	960,118	226,905	190.01
190.02	19002	PHYSICIAN BUILDING	46,081	0	0	46,081	10,890	190.02
190.03	19003	PRIVATE DUTY	985,551	12,829	29,054	1,027,434	242,813	190.03
190.04	19004	MARKETING	1,470,803	0	16,063	1,486,866	351,391	190.04
190.05	19005	SPORTS PHYSICALS	155,706	0	14,040	169,746	40,116	190.05
190.06	19006	FOUNDATION	1,083,612	55,420	23,161	1,162,193	274,661	190.06
190.07	19007	ASC	5,329	647,391	0	652,720	154,257	190.07
190.08	19008	OTHER NONREIMBURSABLE	2,433,928	0	242,621	2,676,549	632,549	190.08
190.09	19009	HANCOCK OB	4,664,577	187,154	325,726	5,177,457	1,223,588	190.09
190.10	19010	HANCOCK WELLNESS	1,072,051	5,453	74,092	1,151,596	272,157	190.10
190.11	19011	MORRISTOWN CLINIC	600	0	0	600	142	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	974,449	0	65,212	1,039,661	245,703	190.13
190.14	19014	3 WEST UNIT	417,485	354,936	20,826	793,247	187,468	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,106,257	52,981	78,611	1,237,849	292,541	190.15

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.16	19016	THORACI	40,577	0	1,838	42,415	10,024	190.16
190.17	19017	HANCOCK ENDO	654,847	0	41,551	696,398	164,580	190.17
190.18	19018	HANCOCK FOOT & ANKLE	755,904	0	52,096	808,000	190,955	190.18
190.19	19019	HANCOCK RHEUM	97,177	0	7,147	104,324	24,655	190.19
194.00	07950	OTHER NONREIMBURSABLE	1,225	0	0	1,225	290	194.00
194.01	07951	SUBURBAN HOSPICE	364,825	91,468	32,962	489,255	115,626	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	128,748,712	14,091,126	5,749,098	128,748,712	24,610,879	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	14,945,920					7.00
9.00	00900	HOUSEKEEPING	66,410	3,309,718				9.00
10.00	01000	DIETARY	615,928	0	950,030			10.00
11.00	01100	CAFETERIA	0	54,983	0	1,770,763		11.00
13.00	01300	NURSING ADMINISTRATION	0	90,604	0	65,027	2,563,462	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	246,704	137,436	0	16,772	30,189	14.00
15.00	01500	PHARMACY	480,804	100,251	0	111,586	200,847	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118,042	120,587	0	47,053	84,693	16.00
23.00	02300	PARAMED ED PRGM	60,716	138,906	0	4,268	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,837,928	921,590	388,944	186,997	336,582	30.00
31.00	03100	INTENSIVE CARE UNIT	1,460,901	189,998	528,287	222,678	400,803	31.00
40.00	04000	SUBPROVIDER - IPF	397,887	152,057	0	28,222	50,797	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	840,494	368,904	0	108,316	194,962	50.00
51.00	05100	RECOVERY ROOM	222,264	135,839	0	14,927	26,868	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,636,651	135,041	0	202,661	364,777	54.00
60.00	06000	LABORATORY	347,151	128,864	0	135,075	243,127	60.00
65.00	06500	RESPIRATORY THERAPY	361,994	98,697	0	95,199	171,352	65.00
66.00	06600	PHYSICAL THERAPY	309,467	114,705	0	58,312	104,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,421	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,823	0	68.00
69.00	06900	ELECTROCARDIOLOGY	295,776	223,653	0	30,986	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	79,782	0	0	5,896	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	214,394	0	0	30,984	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	2,156	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	286,883	0	0	5,802	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1,685	0	90.06
90.07	04951	ONCOLOGY	944,141	0	0	73,583	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	5,694	0	0	23,581	0	90.08
91.00	09100	EMERGENCY	1,006,584	197,603	0	150,405	270,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,836,595	3,309,718	917,231	1,649,415	2,480,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	28,994	52,188	190.03
190.04	19004	MARKETING	0	0	0	8,337	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	123,544	0	0	13,343	0	190.06
190.07	19007	ASC	1,443,178	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	417,208	0	0	36,563	0	190.09
190.10	19010	HANCOCK WELLNESS	12,156	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	791,231	0	0	10,648	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	118,106	0	0	6,463	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	203,902	0	32,799	17,000	30,599	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,945,920	3,309,718	950,030	1,770,763	2,563,462	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	909,389					14.00
15.00	01500	PHARMACY	39,959	4,301,222				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,366,622			16.00
23.00	02300	PARAMED ED PRGM	17	0	0	290,419		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,603	0	368,387	0	10,870,259	30.00
31.00	03100	INTENSIVE CARE UNIT	50,595	0	45,998	0	9,986,433	31.00
40.00	04000	SUBPROVIDER - IPF	984	0	37,928	0	1,535,274	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	218,263	0	484,188	0	8,855,584	50.00
51.00	05100	RECOVERY ROOM	3,681	0	0	0	1,027,061	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,290	0	55,278	290,419	10,768,184	54.00
60.00	06000	LABORATORY	306,839	0	122,661	0	8,085,071	60.00
65.00	06500	RESPIRATORY THERAPY	11,091	0	0	0	3,358,572	65.00
66.00	06600	PHYSICAL THERAPY	1,389	0	0	0	2,476,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	829	0	0	0	495,756	67.00
68.00	06800	SPEECH PATHOLOGY	487	0	0	0	229,017	68.00
69.00	06900	ELECTROCARDIOLOGY	87,407	0	0	0	2,630,476	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	62,945	0	63,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,707,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,301,222	0	0	23,699,950	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	159	0	0	0	223,115	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,602	0	0	0	611,447	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	12,010	0	0	0	1,387,564	90.01
90.02	09002	DIABETES CLINIC	112	0	0	0	48,617	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	139	0	0	0	650,957	90.04
90.05	09005	PRIME TIME	0	0	0	0	45,279	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	46,565	90.06
90.07	04951	ONCOLOGY	9,437	0	0	0	3,568,345	90.07
90.08	04950	ANDERSON WOMENS CENTER	9,555	0	0	0	644,629	90.08
91.00	09100	EMERGENCY	56,883	0	189,237	0	6,979,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	887,331	4,301,222	1,366,622	290,419	100,995,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	1,187,023	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	56,971	190.02
190.03	19003	PRIVATE DUTY	217	0	0	0	1,351,646	190.03
190.04	19004	MARKETING	0	0	0	0	1,846,594	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	209,862	190.05
190.06	19006	FOUNDATION	0	0	0	0	1,573,741	190.06
190.07	19007	ASC	21	0	0	0	2,250,176	190.07
190.08	19008	OTHER NONREIMBURSABLE	2,855	0	0	0	3,311,953	190.08
190.09	19009	HANCOCK OB	9,476	0	0	0	6,864,292	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,435,909	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	742	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	1,285,364	190.13
190.14	19014	3 WEST UNIT	427	0	0	0	1,783,021	190.14
190.15	19015	NEUROLOGY PHYSICIAN	537	0	0	0	1,655,496	190.15
190.16	19016	THORACI	0	0	0	0	52,439	190.16
190.17	19017	HANCOCK ENDO	3,914	0	0	0	864,892	190.17
190.18	19018	HANCOCK FOOT & ANKLE	508	0	0	0	999,463	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	128,979	190.19

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
194.00	07950	OTHER NONREIMBURSABLE	173	0	0	0	1,688	194.00
194.01	07951	SUBURBAN HOSPICE	3,930	0	0	0	893,111	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	909,389	4,301,222	1,366,622	290,419	128,748,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	10,870,259		30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,986,433		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,535,274		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,855,584		50.00
51.00	05100	RECOVERY ROOM	0	1,027,061		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,768,184		54.00
60.00	06000	LABORATORY	0	8,085,071		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,358,572		65.00
66.00	06600	PHYSICAL THERAPY	0	2,476,810		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	495,756		67.00
68.00	06800	SPEECH PATHOLOGY	0	229,017		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,630,476		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,072		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,707,924		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,699,950		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	223,115		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	611,447		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,387,564		90.01
90.02	09002	DIABETES CLINIC	0	48,617		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	650,957		90.04
90.05	09005	PRIME TIME	0	45,279		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	46,565		90.06
90.07	04951	ONCOLOGY	0	3,568,345		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	644,629		90.08
91.00	09100	EMERGENCY	0	6,979,389		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100,995,350		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	1,187,023		190.01
190.02	19002	PHYSICIAN BUILDING	0	56,971		190.02
190.03	19003	PRIVATE DUTY	0	1,351,646		190.03
190.04	19004	MARKETING	0	1,846,594		190.04
190.05	19005	SPORTS PHYSICALS	0	209,862		190.05
190.06	19006	FOUNDATION	0	1,573,741		190.06
190.07	19007	ASC	0	2,250,176		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	3,311,953		190.08
190.09	19009	HANCOCK OB	0	6,864,292		190.09
190.10	19010	HANCOCK WELLNESS	0	1,435,909		190.10
190.11	19011	MORRISTOWN CLINIC	0	742		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,285,364		190.13
190.14	19014	3 WEST UNIT	0	1,783,021		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,655,496		190.15
190.16	19016	THORACI	0	52,439		190.16
190.17	19017	HANCOCK ENDO	0	864,892		190.17

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
190.18	19018	HANCOCK FOOT & ANKLE	0	999,463		190.18
190.19	19019	HANCOCK RHEUM	0	128,979		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	1,688		194.00
194.01	07951	SUBURBAN HOSPICE	0	893,111		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	128,748,712		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	72,468	72,468	72,468		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,219,875	1,219,875	15,609	1,235,484	5.00
7.00	00700	OPERATION OF PLANT	0	5,299,153	5,299,153	1,519	143,423	7.00
9.00	00900	HOUSEKEEPING	0	29,791	29,791	2,169	31,123	9.00
10.00	01000	DIETARY	0	276,297	276,297	576	3,206	10.00
11.00	01100	CAFETERIA	0	0	0	1,359	16,465	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,856	23,106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	110,668	110,668	251	4,590	14.00
15.00	01500	PHARMACY	0	215,682	215,682	2,916	32,318	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,952	52,952	741	9,560	16.00
23.00	02300	PARAMED ED PRGM	0	27,237	27,237	118	830	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	824,472	824,472	4,438	65,131	30.00
31.00	03100	INTENSIVE CARE UNIT	0	655,341	655,341	4,810	68,010	31.00
40.00	04000	SUBPROVIDER - IPF	0	178,487	178,487	498	8,324	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	377,035	377,035	4,391	63,723	50.00
51.00	05100	RECOVERY ROOM	0	99,705	99,705	402	5,983	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	734,181	734,181	4,450	77,307	54.00
60.00	06000	LABORATORY	0	155,727	155,727	2,225	65,267	60.00
65.00	06500	RESPIRATORY THERAPY	0	162,386	162,386	1,946	25,144	65.00
66.00	06600	PHYSICAL THERAPY	0	138,823	138,823	1,389	18,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	406	4,563	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	187	2,118	68.00
69.00	06900	ELECTROCARDIOLOGY	0	132,681	132,681	713	19,122	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	25,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	186,142	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	35,789	35,789	75	1,317	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	323	5,795	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	96,174	96,174	605	10,845	90.01
90.02	09002	DIABETES CLINIC	0	0	0	35	445	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	128,692	128,692	122	3,437	90.04
90.05	09005	PRIME TIME	0	0	0	0	435	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	39	431	90.06
90.07	04951	ONCOLOGY	0	423,529	423,529	1,523	24,386	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,554	2,554	427	5,813	90.08
91.00	09100	EMERGENCY	0	451,541	451,541	3,432	49,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,901,240	11,901,240	59,550	1,001,480	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	782,254	782,254	0	11,391	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	547	190.02
190.03	19003	PRIVATE DUTY	0	12,829	12,829	366	12,189	190.03
190.04	19004	MARKETING	0	0	0	202	17,640	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	177	2,014	190.05
190.06	19006	FOUNDATION	0	55,420	55,420	292	13,788	190.06
190.07	19007	ASC	0	647,391	647,391	0	7,744	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	3,058	31,755	190.08
190.09	19009	HANCOCK OB	0	187,154	187,154	4,105	61,425	190.09
190.10	19010	HANCOCK WELLNESS	0	5,453	5,453	934	13,663	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	7	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	822	12,335	190.13
190.14	19014	3 WEST UNIT	0	354,936	354,936	262	9,411	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	52,981	52,981	991	14,686	190.15
190.16	19016	THORACI	0	0	0	23	503	190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.17	19017	HANCOCK ENDO	0	0	0	524	8,262	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	657	9,586	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	90	1,238	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	15	194.00
194.01	07951	SUBURBAN HOSPICE	0	91,468	91,468	415	5,805	194.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	14,091,126	14,091,126	72,468	1,235,484	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	5,444,095					7.00
9.00	00900	HOUSEKEEPING	24,190	87,273				9.00
10.00	01000	DIETARY	224,353	0	478,368			10.00
11.00	01100	CAFETERIA	0	1,450	0	19,274		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,389	0	708	28,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,863	3,624	0	183	330	14.00
15.00	01500	PHARMACY	175,134	2,643	0	1,215	2,198	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,997	3,180	0	512	927	16.00
23.00	02300	PARAMED ED PRGM	22,116	3,663	0	46	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	669,473	24,299	195,845	2,035	3,684	30.00
31.00	03100	INTENSIVE CARE UNIT	532,137	5,010	266,008	2,426	4,388	31.00
40.00	04000	SUBPROVIDER - IPF	144,931	4,010	0	307	556	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	306,153	9,728	0	1,179	2,134	50.00
51.00	05100	RECOVERY ROOM	80,960	3,582	0	162	294	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	596,155	3,561	0	2,206	3,993	54.00
60.00	06000	LABORATORY	126,451	3,398	0	1,470	2,661	60.00
65.00	06500	RESPIRATORY THERAPY	131,857	2,603	0	1,036	1,876	65.00
66.00	06600	PHYSICAL THERAPY	112,724	3,025	0	635	1,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	211	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,737	5,897	0	337	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	29,061	0	0	64	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	78,094	0	0	337	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	23	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	104,498	0	0	63	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	18	0	90.06
90.07	04951	ONCOLOGY	343,906	0	0	801	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	2,074	0	0	257	0	90.08
91.00	09100	EMERGENCY	366,651	5,211	0	1,637	2,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,311,515	87,273	461,853	17,953	27,153	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	316	571	190.03
190.04	19004	MARKETING	0	0	0	91	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	45,001	0	0	145	0	190.06
190.07	19007	ASC	525,682	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	151,969	0	0	398	0	190.09
190.10	19010	HANCOCK WELLNESS	4,428	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	288,208	0	0	116	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	43,020	0	0	70	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	74,272	0	16,515	185	335	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	26,064	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,444,095	87,273	504,432	19,274	28,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	209,509					14.00
15.00	01500	PHARMACY	9,206	441,312				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	110,869			16.00
23.00	02300	PARAMED ED PRGM	4	0	0	54,014		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,815	0	29,886		1,829,078	30.00
31.00	03100	INTENSIVE CARE UNIT	11,656	0	3,732		1,553,518	31.00
40.00	04000	SUBPROVIDER - IPF	227	0	3,077		340,417	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,284	0	39,280		853,907	50.00
51.00	05100	RECOVERY ROOM	848	0	0		191,936	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,287	0	4,485		1,432,625	54.00
60.00	06000	LABORATORY	70,691	0	9,951		437,841	60.00
65.00	06500	RESPIRATORY THERAPY	2,555	0	0		329,403	65.00
66.00	06600	PHYSICAL THERAPY	320	0	0		276,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	191	0	0		5,371	67.00
68.00	06800	SPEECH PATHOLOGY	112	0	0		2,502	68.00
69.00	06900	ELECTROCARDIOLOGY	20,137	0	0		286,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,106		5,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		25,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	441,312	0		627,454	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	37	0	0		66,343	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,751	0	0		7,869	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	2,767	0	0		188,822	90.01
90.02	09002	DIABETES CLINIC	26	0	0		529	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	32	0	0		236,844	90.04
90.05	09005	PRIME TIME	0	0	0		435	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		488	90.06
90.07	04951	ONCOLOGY	2,174	0	0		796,319	90.07
90.08	04950	ANDERSON WOMENS CENTER	2,201	0	0		13,326	90.08
91.00	09100	EMERGENCY	13,105	0	15,352		908,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,426	441,312	110,869	0	10,417,835	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		793,645	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		547	190.02
190.03	19003	PRIVATE DUTY	50	0	0		26,321	190.03
190.04	19004	MARKETING	0	0	0		17,933	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		2,191	190.05
190.06	19006	FOUNDATION	0	0	0		114,646	190.06
190.07	19007	ASC	5	0	0		1,180,822	190.07
190.08	19008	OTHER NONREIMBURSABLE	658	0	0		35,471	190.08
190.09	19009	HANCOCK OB	2,183	0	0		407,234	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		24,478	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		7	190.11
190.12	19012	O3PUREMED	0	0	0		0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		13,157	190.13
190.14	19014	3 WEST UNIT	98	0	0		653,031	190.14
190.15	19015	NEUROLOGY PHYSICIAN	124	0	0		111,872	190.15
190.16	19016	THORACI	0	0	0		526	190.16
190.17	19017	HANCOCK ENDO	902	0	0		9,688	190.17
190.18	19018	HANCOCK FOOT & ANKLE	117	0	0		10,360	190.18
190.19	19019	HANCOCK RHEUM	0	0	0		1,328	190.19

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
194.00	07950	OTHER NONREIMBURSABLE	40	0	0		55	194.00
194.01	07951	SUBURBAN HOSPICE	906	0	0		189,901	194.01
200.00		Cross Foot Adjustments				54,014	54,014	200.00
201.00		Negative Cost Centers	0	0	0	0	26,064	201.00
202.00		TOTAL (sum lines 118 through 201)	209,509	441,312	110,869	54,014	14,091,126	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,829,078		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,553,518		31.00
40.00	04000	SUBPROVIDER - IPF	0	340,417		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	853,907		50.00
51.00	05100	RECOVERY ROOM	0	191,936		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,432,625		54.00
60.00	06000	LABORATORY	0	437,841		60.00
65.00	06500	RESPIRATORY THERAPY	0	329,403		65.00
66.00	06600	PHYSICAL THERAPY	0	276,182		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,371		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,502		68.00
69.00	06900	ELECTROCARDIOLOGY	0	286,624		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,107		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	25,986		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	627,454		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	66,343		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,869		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	188,822		90.01
90.02	09002	DIABETES CLINIC	0	529		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	236,844		90.04
90.05	09005	PRIME TIME	0	435		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	488		90.06
90.07	04951	ONCOLOGY	0	796,319		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	13,326		90.08
91.00	09100	EMERGENCY	0	908,909		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,417,835		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	793,645		190.01
190.02	19002	PHYSICIAN BUILDING	0	547		190.02
190.03	19003	PRIVATE DUTY	0	26,321		190.03
190.04	19004	MARKETING	0	17,933		190.04
190.05	19005	SPORTS PHYSICALS	0	2,191		190.05
190.06	19006	FOUNDATION	0	114,646		190.06
190.07	19007	ASC	0	1,180,822		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	35,471		190.08
190.09	19009	HANCOCK OB	0	407,234		190.09
190.10	19010	HANCOCK WELLNESS	0	24,478		190.10
190.11	19011	MORRISTOWN CLINIC	0	7		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	13,157		190.13
190.14	19014	3 WEST UNIT	0	653,031		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	111,872		190.15
190.16	19016	THORACI	0	526		190.16
190.17	19017	HANCOCK ENDO	0	9,688		190.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
190.18	19018	HANCOCK FOOT & ANKLE	0	10,360		190.18
190.19	19019	HANCOCK RHEUM	0	1,328		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	55		194.00
194.01	07951	SUBURBAN HOSPICE	0	189,901		194.01
200.00		Cross Foot Adjustments	0	54,014		200.00
201.00		Negative Cost Centers	0	26,064		201.00
202.00		TOTAL (sum lines 118 through 201)	0	14,091,126		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	490,976					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,525	57,054,848				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	42,504	12,284,426	-24,610,879	104,137,833		5.00
7.00	00700	OPERATION OF PLANT	184,638	1,195,827	0	12,088,941	233,606	7.00
9.00	00900	HOUSEKEEPING	1,038	1,707,756	0	2,623,335	1,038	9.00
10.00	01000	DIETARY	9,627	453,571	0	270,237	9,627	10.00
11.00	01100	CAFETERIA	0	1,069,935	0	1,387,801	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,461,271	0	1,947,563	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,856	197,622	0	386,861	3,856	14.00
15.00	01500	PHARMACY	7,515	2,296,179	0	2,724,010	7,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,845	583,334	0	805,810	1,845	16.00
23.00	02300	PARAMED ED PRGM	949	92,598	0	69,975	949	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,727	3,494,265	0	5,489,819	28,727	30.00
31.00	03100	INTENSIVE CARE UNIT	22,834	3,787,335	0	5,732,428	22,834	31.00
40.00	04000	SUBPROVIDER - IPF	6,219	391,747	0	701,592	6,219	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,137	3,457,230	0	5,371,104	13,137	50.00
51.00	05100	RECOVERY ROOM	3,474	316,579	0	504,301	3,474	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,581	3,503,954	0	6,516,114	25,581	54.00
60.00	06000	LABORATORY	5,426	1,752,218	0	5,501,245	5,426	60.00
65.00	06500	RESPIRATORY THERAPY	5,658	1,532,454	0	2,119,369	5,658	65.00
66.00	06600	PHYSICAL THERAPY	4,837	1,094,004	0	1,527,083	4,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	319,936	0	384,611	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	147,071	0	178,518	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,623	561,620	0	1,611,749	4,623	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	103	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,190,292	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,690,587	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	1,247	59,313	0	111,037	1,247	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	254,537	0	488,417	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,351	476,436	0	914,138	3,351	90.01
90.02	09002	DIABETES CLINIC	0	27,482	0	37,489	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	4,484	95,949	0	289,674	4,484	90.04
90.05	09005	PRIME TIME	0	0	0	36,624	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	30,680	0	36,301	0	90.06
90.07	04951	ONCOLOGY	14,757	1,198,949	0	2,055,425	14,757	90.07
90.08	04950	ANDERSON WOMENS CENTER	89	335,973	0	489,998	89	90.08
91.00	09100	EMERGENCY	15,733	2,702,320	0	4,131,548	15,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	414,674	46,882,571	-24,610,879	84,414,099	185,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	27,256	0	0	960,118	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	46,081	0	190.02
190.03	19003	PRIVATE DUTY	447	288,341	0	1,027,434	0	190.03
190.04	19004	MARKETING	0	159,416	0	1,486,866	0	190.04
190.05	19005	SPORTS PHYSICALS	0	139,338	0	169,746	0	190.05
190.06	19006	FOUNDATION	1,931	229,854	0	1,162,193	1,931	190.06
190.07	19007	ASC	22,557	0	0	652,720	22,557	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	2,407,810	0	2,676,549	0	190.08
190.09	19009	HANCOCK OB	6,521	3,232,566	0	5,177,457	6,521	190.09
190.10	19010	HANCOCK WELLNESS	190	735,300	0	1,151,596	190	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	600	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	647,179	0	1,039,661	0	190.13
190.14	19014	3 WEST UNIT	12,367	206,680	0	793,247	12,367	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,846	780,147	0	1,237,849	1,846	190.15

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.16	19016	THORACI	0	18,236	0	42,415	0	190.16
190.17	19017	HANCOCK ENDO	0	412,355	0	696,398	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	517,007	0	808,000	0	190.18
190.19	19019	HANCOCK RHEUM	0	70,932	0	104,324	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	1,225	0	194.00
194.01	07951	SUBURBAN HOSPICE	3,187	327,116	0	489,255	3,187	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	14,091,126	5,749,098		24,610,879	14,945,920	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.700234	0.100764		0.236330	63.979179	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		72,468		1,235,484	5,444,095	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001270		0.011864	23.304603	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	393,860					9.00
10.00	01000	DIETARY	0	9,211				10.00
11.00	01100	CAFETERIA	6,543	0	809,036			11.00
13.00	01300	NURSING ADMINISTRATION	10,782	0	29,710	650,695		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	7,663	7,663	6,118,110	14.00
15.00	01500	PHARMACY	11,930	0	50,982	50,982	268,835	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	21,498	21,498	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,950	0	113	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,771	85,436	85,436	286,621	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	5,122	101,738	101,738	340,389	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	0	12,894	12,894	6,618	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	49,488	49,488	1,468,411	50.00
51.00	05100	RECOVERY ROOM	16,165	0	6,820	6,820	24,766	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	92,593	92,593	183,597	54.00
60.00	06000	LABORATORY	15,335	0	61,714	61,714	2,064,328	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	43,495	43,495	74,617	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	26,642	26,642	9,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,873	0	5,578	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,574	0	3,274	68.00
69.00	06900	ELECTROCARDIOLOGY	26,615	0	14,157	0	588,047	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,694	0	1,069	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	51,146	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	14,156	0	80,803	90.01
90.02	09002	DIABETES CLINIC	0	0	985	0	751	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	2,651	0	932	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	770	0	0	90.06
90.07	04951	ONCOLOGY	0	0	33,619	0	63,490	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	10,774	0	64,284	90.08
91.00	09100	EMERGENCY	23,515	0	68,718	68,718	382,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	393,860	8,893	753,594	629,681	5,969,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	13,247	13,247	1,463	190.03
190.04	19004	MARKETING	0	0	3,809	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	6,096	0	0	190.06
190.07	19007	ASC	0	0	0	0	140	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	19,208	190.08
190.09	19009	HANCOCK OB	0	0	16,705	0	63,753	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	4,865	0	2,872	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	2,953	0	3,610	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	26,331	190.17

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	3,417	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	1,166	194.00
194.01	07951	SUBURBAN HOSPICE	0	318	7,767	7,767	26,443	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,309,718	950,030	1,770,763	2,563,462	909,389	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.403285	103.140810	2.188732	3.939575	0.148639	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,273	504,432	19,274	28,059	209,509	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.221584	51.934426	0.023823	0.043122	0.034244	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,387			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	94	0		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	3,387	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
190.16	19016	THORACI	0	0	0		190.16
190.17	19017	HANCOCK ENDO	0	0	0		190.17

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 10:15 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	0	0		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,301,222	1,366,622	290,419		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43,012.220000	403.490404	2,904.190000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	441,312	110,869	54,014		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4,413.120000	32.733688	540.140000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 10:15 am

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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	10,870,259		10,870,259	0	10,870,259	30.00
31.00	03100	INTENSIVE CARE UNIT	9,986,433		9,986,433	0	9,986,433	31.00
40.00	04000	SUBPROVIDER - IPF	1,535,274		1,535,274	0	1,535,274	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,855,584		8,855,584	0	8,855,584	50.00
51.00	05100	RECOVERY ROOM	1,027,061		1,027,061	0	1,027,061	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,768,184		10,768,184	0	10,768,184	54.00
60.00	06000	LABORATORY	8,085,071		8,085,071	0	8,085,071	60.00
65.00	06500	RESPIRATORY THERAPY	3,358,572	0	3,358,572	0	3,358,572	65.00
66.00	06600	PHYSICAL THERAPY	2,476,810	0	2,476,810	0	2,476,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	495,756	0	495,756	0	495,756	67.00
68.00	06800	SPEECH PATHOLOGY	229,017	0	229,017	0	229,017	68.00
69.00	06900	ELECTROCARDIOLOGY	2,630,476		2,630,476	0	2,630,476	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,072		63,072	0	63,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,707,924		2,707,924	0	2,707,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,699,950		23,699,950	0	23,699,950	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	223,115		223,115	0	223,115	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	611,447		611,447	0	611,447	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,387,564		1,387,564	0	1,387,564	90.01
90.02	09002	DIABETES CLINIC	48,617		48,617	0	48,617	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	650,957		650,957	0	650,957	90.04
90.05	09005	PRIME TIME	45,279		45,279	0	45,279	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	46,565		46,565	0	46,565	90.06
90.07	04951	ONCOLOGY	3,568,345		3,568,345	0	3,568,345	90.07
90.08	04950	ANDERSON WOMENS CENTER	644,629		644,629	0	644,629	90.08
91.00	09100	EMERGENCY	6,979,389		6,979,389	0	6,979,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,694,765		5,694,765		5,694,765	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	106,690,115	0	106,690,115	0	106,690,115	200.00
201.00		Less Observation Beds	5,694,765		5,694,765		5,694,765	201.00
202.00		Total (see instructions)	100,995,350	0	100,995,350	0	100,995,350	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 10:15 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,973,421		6,973,421			30.00
31.00	03100	INTENSIVE CARE UNIT	11,784,452		11,784,452			31.00
40.00	04000	SUBPROVIDER - IPF	768,357		768,357			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,652,207	15,746,157	23,398,364	0.378470	0.000000	50.00
51.00	05100	RECOVERY ROOM	653,059	1,277,118	1,930,177	0.532107	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,782,216	67,152,816	69,935,032	0.153974	0.000000	54.00
60.00	06000	LABORATORY	5,534,446	43,410,451	48,944,897	0.165187	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,195,813	6,327,649	9,523,462	0.352663	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	531,749	3,886,700	4,418,449	0.560561	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,060	672,269	1,089,329	0.455102	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	139,614	335,957	475,571	0.481562	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,941,309	12,632,847	15,574,156	0.168900	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	525,707	1,120,367	1,646,074	0.038317	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,629,583	4,065,857	6,695,440	0.404443	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,292,346	81,972,685	90,265,031	0.262560	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	416,340	416,340	0.535896	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	15,676	4,783,805	4,799,481	0.289107	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	23,797	23,797	2.042989	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	40,195	40,195	16.194974	0.000000	90.04
90.05	09005	PRIME TIME	0	323,945	323,945	0.139774	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	154	154	302.370130	0.000000	90.06
90.07	04951	ONCOLOGY	16,752	6,556,008	6,572,760	0.542899	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,083,396	3,083,396	0.209065	0.000000	90.08
91.00	09100	EMERGENCY	4,222,555	45,549,583	49,772,138	0.140227	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,395	8,801,812	9,061,207	0.628478	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	326	326			116.00
200.00		Subtotal (see instructions)	59,335,717	308,180,234	367,515,951			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	59,335,717	308,180,234	367,515,951			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 10:15 am

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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.378470	50.00
51.00	05100	RECOVERY ROOM	0.532107	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153974	54.00
60.00	06000	LABORATORY	0.165187	60.00
65.00	06500	RESPIRATORY THERAPY	0.352663	65.00
66.00	06600	PHYSICAL THERAPY	0.560561	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455102	67.00
68.00	06800	SPEECH PATHOLOGY	0.481562	68.00
69.00	06900	ELECTROCARDIOLOGY	0.168900	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.038317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.404443	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262560	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.535896	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.289107	90.01
90.02	09002	DIABETES CLINIC	2.042989	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	16.194974	90.04
90.05	09005	PRIME TIME	0.139774	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	302.370130	90.06
90.07	04951	ONCOLOGY	0.542899	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.209065	90.08
91.00	09100	EMERGENCY	0.140227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.628478	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,870,259		10,870,259	0	10,870,259	30.00
31.00	03100	INTENSIVE CARE UNIT	9,986,433		9,986,433	0	9,986,433	31.00
40.00	04000	SUBPROVIDER - IPF	1,535,274		1,535,274	0	1,535,274	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,855,584		8,855,584	0	8,855,584	50.00
51.00	05100	RECOVERY ROOM	1,027,061		1,027,061	0	1,027,061	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,768,184		10,768,184	0	10,768,184	54.00
60.00	06000	LABORATORY	8,085,071		8,085,071	0	8,085,071	60.00
65.00	06500	RESPIRATORY THERAPY	3,358,572	0	3,358,572	0	3,358,572	65.00
66.00	06600	PHYSICAL THERAPY	2,476,810	0	2,476,810	0	2,476,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	495,756	0	495,756	0	495,756	67.00
68.00	06800	SPEECH PATHOLOGY	229,017	0	229,017	0	229,017	68.00
69.00	06900	ELECTROCARDIOLOGY	2,630,476		2,630,476	0	2,630,476	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,072		63,072	0	63,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,707,924		2,707,924	0	2,707,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,699,950		23,699,950	0	23,699,950	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	223,115		223,115	0	223,115	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	611,447		611,447	0	611,447	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,387,564		1,387,564	0	1,387,564	90.01
90.02	09002	DIABETES CLINIC	48,617		48,617	0	48,617	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	650,957		650,957	0	650,957	90.04
90.05	09005	PRIME TIME	45,279		45,279	0	45,279	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	46,565		46,565	0	46,565	90.06
90.07	04951	ONCOLOGY	3,568,345		3,568,345	0	3,568,345	90.07
90.08	04950	ANDERSON WOMENS CENTER	644,629		644,629	0	644,629	90.08
91.00	09100	EMERGENCY	6,979,389		6,979,389	0	6,979,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,694,765		5,694,765		5,694,765	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	106,690,115	0	106,690,115	0	106,690,115	200.00
201.00		Less Observation Beds	5,694,765		5,694,765		5,694,765	201.00
202.00		Total (see instructions)	100,995,350	0	100,995,350	0	100,995,350	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,973,421		6,973,421			30.00
31.00	03100	INTENSIVE CARE UNIT	11,784,452		11,784,452			31.00
40.00	04000	SUBPROVIDER - IPF	768,357		768,357			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,652,207	15,746,157	23,398,364	0.378470	0.000000	50.00
51.00	05100	RECOVERY ROOM	653,059	1,277,118	1,930,177	0.532107	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,782,216	67,152,816	69,935,032	0.153974	0.000000	54.00
60.00	06000	LABORATORY	5,534,446	43,410,451	48,944,897	0.165187	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,195,813	6,327,649	9,523,462	0.352663	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	531,749	3,886,700	4,418,449	0.560561	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,060	672,269	1,089,329	0.455102	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	139,614	335,957	475,571	0.481562	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,941,309	12,632,847	15,574,156	0.168900	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	525,707	1,120,367	1,646,074	0.038317	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,629,583	4,065,857	6,695,440	0.404443	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,292,346	81,972,685	90,265,031	0.262560	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	416,340	416,340	0.535896	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	15,676	4,783,805	4,799,481	0.289107	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	23,797	23,797	2.042989	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	40,195	40,195	16.194974	0.000000	90.04
90.05	09005	PRIME TIME	0	323,945	323,945	0.139774	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	154	154	302.370130	0.000000	90.06
90.07	04951	ONCOLOGY	16,752	6,556,008	6,572,760	0.542899	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,083,396	3,083,396	0.209065	0.000000	90.08
91.00	09100	EMERGENCY	4,222,555	45,549,583	49,772,138	0.140227	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,395	8,801,812	9,061,207	0.628478	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	326	326			116.00
200.00		Subtotal (see instructions)	59,335,717	308,180,234	367,515,951			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	59,335,717	308,180,234	367,515,951			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 10:15 am

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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.000000	90.01
90.02	09002	DIABETES CLINIC	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	0.000000	90.04
90.05	09005	PRIME TIME	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	90.06
90.07	04951	ONCOLOGY	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,829,078	0	1,829,078	7,452	245.45	30.00
31.00	INTENSIVE CARE UNIT	1,553,518		1,553,518	5,155	301.36	31.00
40.00	SUBPROVIDER - IPF	340,417	0	340,417	555	613.36	40.00
200.00	Total (lines 30 through 199)	3,723,013		3,723,013	13,162		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	895	219,678	30.00
31.00	INTENSIVE CARE UNIT	1,848	556,913	31.00
40.00	SUBPROVIDER - IPF	476	291,959	40.00
200.00	Total (lines 30 through 199)	3,219	1,068,550	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/29/2021 10:15 am

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	853,907	23,398,364	0.036494	2,579,273	94,128	50.00
51.00	05100	RECOVERY ROOM	191,936	1,930,177	0.099440	216,203	21,499	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,432,625	69,935,032	0.020485	2,567,940	52,604	54.00
60.00	06000	LABORATORY	437,841	48,944,897	0.008946	3,626,311	32,441	60.00
65.00	06500	RESPIRATORY THERAPY	329,403	9,523,462	0.034589	894,442	30,938	65.00
66.00	06600	PHYSICAL THERAPY	276,182	4,418,449	0.062507	224,575	14,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,371	1,089,329	0.004931	171,194	844	67.00
68.00	06800	SPEECH PATHOLOGY	2,502	475,571	0.005261	60,576	319	68.00
69.00	06900	ELECTROCARDIOLOGY	286,624	15,574,156	0.018404	2,064,034	37,986	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,107	1,646,074	0.003103	205,555	638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	25,986	6,695,440	0.003881	1,103,866	4,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	627,454	90,265,031	0.006951	3,427,858	23,827	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	66,343	416,340	0.159348	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,869	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	188,822	4,799,481	0.039342	0	0	90.01
90.02	09002	DIABETES CLINIC	529	23,797	0.022230	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	236,844	40,195	5.892375	0	0	90.04
90.05	09005	PRIME TIME	435	323,945	0.001343	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	488	154	3.168831	0	0	90.06
90.07	04951	ONCOLOGY	796,319	6,572,760	0.121154	10,679	1,294	90.07
90.08	04950	ANDERSON WOMENS CENTER	13,326	3,083,396	0.004322	0	0	90.08
91.00	09100	EMERGENCY	908,909	49,772,138	0.018261	4,102,584	74,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,224	9,061,207	0.105750	259,395	27,431	92.00
200.00		Total (lines 50 through 199)	7,653,046	347,989,395		21,514,485	417,188	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/29/2021 10:15 am

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
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,452	0.00	895	30.00
31.00	03100	INTENSIVE CARE UNIT		0	5,155	0.00	1,848	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	555	0.00	476	40.00
200.00		Total (lines 30 through 199)		0	13,162		3,219	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/29/2021 10:15 am

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	290,419	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	290,419	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 10:15 am

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	23,398,364	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,930,177	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	290,419	290,419	69,935,032	0.004153	54.00
60.00	06000	LABORATORY	0	0	0	48,944,897	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,523,462	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,418,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,089,329	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	475,571	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,574,156	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,646,074	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,695,440	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	90,265,031	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	416,340	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,799,481	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	23,797	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	40,195	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	323,945	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	154	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	6,572,760	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,083,396	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	49,772,138	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	9,061,207	0.000000	92.00
200.00		Total (lines 50 through 199)	0	290,419	290,419	347,989,395		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 10:15 am

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	2,579,273	0	3,806,351	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	216,203	0	220,214	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004153	2,567,940	10,665	18,352,558	76,218	54.00
60.00	06000	LABORATORY	0.000000	3,626,311	0	5,070,048	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	894,442	0	1,278,433	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	224,575	0	24,261	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	171,194	0	9,962	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	60,576	0	36,381	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,064,034	0	2,578,816	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	205,555	0	192,021	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,103,866	0	945,495	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,427,858	0	28,772,342	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	97,255	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	0	0	1,638,304	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	10,679	0	1,275,096	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	56,009	0	90.08
91.00	09100	EMERGENCY	0.000000	4,102,584	0	7,467,931	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	259,395	0	2,940,586	0	92.00
200.00		Total (lines 50 through 199)		21,514,485	10,665	74,762,063	76,218	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.378470	3,806,351	0	0	1,440,590	50.00
51.00	05100	RECOVERY ROOM	0.532107	220,214	0	0	117,177	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153974	18,352,558	0	0	2,825,817	54.00
60.00	06000	LABORATORY	0.165187	5,070,048	0	0	837,506	60.00
65.00	06500	RESPIRATORY THERAPY	0.352663	1,278,433	0	0	450,856	65.00
66.00	06600	PHYSICAL THERAPY	0.560561	24,261	0	0	13,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455102	9,962	0	0	4,534	67.00
68.00	06800	SPEECH PATHOLOGY	0.481562	36,381	0	0	17,520	68.00
69.00	06900	ELECTROCARDIOLOGY	0.168900	2,578,816	0	0	435,562	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.038317	192,021	0	0	7,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.404443	945,495	0	0	382,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262560	28,772,342	0	8,014	7,554,466	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.535896	97,255	0	0	52,119	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.289107	1,638,304	0	0	473,645	90.01
90.02	09002	DIABETES CLINIC	2.042989	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	16.194974	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.139774	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	302.370130	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.542899	1,275,096	0	0	692,248	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.209065	56,009	0	0	11,710	90.08
91.00	09100	EMERGENCY	0.140227	7,467,931	0	0	1,047,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.628478	2,940,586	0	0	1,848,094	92.00
200.00		Subtotal (see instructions)		74,762,063	0	8,014	18,212,407	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		74,762,063	0	8,014	18,212,407	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,104		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0		90.08
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	2,104		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,104		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/29/2021 10:15 am

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	853,907	23,398,364	0.036494	0	0	50.00
51.00	05100	RECOVERY ROOM	191,936	1,930,177	0.099440	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,432,625	69,935,032	0.020485	32,395	664	54.00
60.00	06000	LABORATORY	437,841	48,944,897	0.008946	102,178	914	60.00
65.00	06500	RESPIRATORY THERAPY	329,403	9,523,462	0.034589	18,635	645	65.00
66.00	06600	PHYSICAL THERAPY	276,182	4,418,449	0.062507	5,711	357	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,371	1,089,329	0.004931	19,143	94	67.00
68.00	06800	SPEECH PATHOLOGY	2,502	475,571	0.005261	3,009	16	68.00
69.00	06900	ELECTROCARDIOLOGY	286,624	15,574,156	0.018404	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,107	1,646,074	0.003103	6,613	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	25,986	6,695,440	0.003881	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	627,454	90,265,031	0.006951	56,516	393	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	66,343	416,340	0.159348	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,869	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	188,822	4,799,481	0.039342	0	0	90.01
90.02	09002	DIABETES CLINIC	529	23,797	0.022230	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	236,844	40,195	5.892375	0	0	90.04
90.05	09005	PRIME TIME	435	323,945	0.001343	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	488	154	3.168831	0	0	90.06
90.07	04951	ONCOLOGY	796,319	6,572,760	0.121154	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	13,326	3,083,396	0.004322	0	0	90.08
91.00	09100	EMERGENCY	908,909	49,772,138	0.018261	23,996	438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	9,061,207	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	6,694,822	347,989,395		268,196	3,542	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 10:15 am

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	290,419	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	290,419	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 10:15 am

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	23,398,364	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,930,177	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	290,419	290,419	69,935,032	0.004153	54.00
60.00	06000	LABORATORY	0	0	0	48,944,897	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,523,462	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,418,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,089,329	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	475,571	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,574,156	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,646,074	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,695,440	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	90,265,031	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	416,340	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,799,481	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	23,797	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	40,195	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	323,945	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	154	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	6,572,760	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,083,396	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	49,772,138	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	9,061,207	0.000000	92.00
200.00		Total (lines 50 through 199)	0	290,419	290,419	347,989,395		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/29/2021 10:15 am

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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004153	32,395	135	0	0	54.00
60.00	06000	LABORATORY	0.000000	102,178	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	18,635	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,711	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	19,143	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,009	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,613	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	56,516	0	0	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	23,996	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		268,196	135	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,452	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,452	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)	3,548	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)	895	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)	10,870,259	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)	10,870,259	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)	10,870,259	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)	1,458.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,305,537	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)	1,305,537	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,986,433	5,155	1,937.23	1,848	3,580,001	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)	5,081,117	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,966,655	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)	776,591	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	427,853	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,204,444	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,762,211	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)	3,904	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,458.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,694,765	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,829,078	10,870,259	0.168264	5,694,765	958,224	90.00
91.00	Nursing School cost	0	10,870,259	0.000000	5,694,765	0	91.00
92.00	Allied health cost	0	10,870,259	0.000000	5,694,765	0	92.00
93.00	All other Medical Education	0	10,870,259	0.000000	5,694,765	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037 Component CCN: 15-S037	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 10:15 am
	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)	555	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	555	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)	555	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)	476	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)	1,535,274	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)	1,535,274	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)	1,535,274	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)	2,766.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,316,740	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)	1,316,740	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

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)						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)	60,257	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,376,997	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)	291,959	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,677	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	295,636	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,081,361	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: 15-0037 Component CCN: 15-S037	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 10:15 am
	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	340,417	1,535,274	0.221730	0	0	90.00
91.00	Nursing School cost	0	1,535,274	0.000000	0	0	91.00
92.00	Allied health cost	0	1,535,274	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,535,274	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

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)	7,452	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,452	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)	3,548	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)	107	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)	10,870,259	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)	10,870,259	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)	10,870,259	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)	1,458.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	156,081	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)	156,081	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,986,433	5,155	1,937.23	146	282,836	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)	328,433	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	767,350	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)	3,904	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,458.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,694,765	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 10:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,829,078	10,870,259	0.168264	5,694,765	958,224	90.00
91.00	Nursing School cost	0	10,870,259	0.000000	5,694,765	0	91.00
92.00	Allied health cost	0	10,870,259	0.000000	5,694,765	0	92.00
93.00	All other Medical Education	0	10,870,259	0.000000	5,694,765	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 10:15 am

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		855,966		30.00
31.00	03100	INTENSIVE CARE UNIT		4,659,678		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.378470	2,579,273	976,177	50.00
51.00	05100	RECOVERY ROOM	0.532107	216,203	115,043	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153974	2,567,940	395,396	54.00
60.00	06000	LABORATORY	0.165187	3,626,311	599,019	60.00
65.00	06500	RESPIRATORY THERAPY	0.352663	894,442	315,437	65.00
66.00	06600	PHYSICAL THERAPY	0.560561	224,575	125,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455102	171,194	77,911	67.00
68.00	06800	SPEECH PATHOLOGY	0.481562	60,576	29,171	68.00
69.00	06900	ELECTROCARDIOLOGY	0.168900	2,064,034	348,615	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.038317	205,555	7,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.404443	1,103,866	446,451	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262560	3,427,858	900,018	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.535896	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.289107	0	0	90.01
90.02	09002	DIABETES CLINIC	2.042989	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	16.194974	0	0	90.04
90.05	09005	PRIME TIME	0.139774	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	302.370130	0	0	90.06
90.07	04951	ONCOLOGY	0.542899	10,679	5,798	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.209065	0	0	90.08
91.00	09100	EMERGENCY	0.140227	4,102,584	575,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.628478	259,395	163,024	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,514,485	5,081,117	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)		21,514,485		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3

Component CCN: 15-S037 | Date/Time Prepared: 7/29/2021 10:15 am

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		656,383		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.378470	0	0	50.00
51.00	05100	RECOVERY ROOM	0.532107	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153974	32,395	4,988	54.00
60.00	06000	LABORATORY	0.165187	102,178	16,878	60.00
65.00	06500	RESPIRATORY THERAPY	0.352663	18,635	6,572	65.00
66.00	06600	PHYSICAL THERAPY	0.560561	5,711	3,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455102	19,143	8,712	67.00
68.00	06800	SPEECH PATHOLOGY	0.481562	3,009	1,449	68.00
69.00	06900	ELECTROCARDIOLOGY	0.168900	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.038317	6,613	253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.404443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262560	56,516	14,839	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.535896	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.289107	0	0	90.01
90.02	09002	DIABETES CLINIC	2.042989	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	16.194974	0	0	90.04
90.05	09005	PRIME TIME	0.139774	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	302.370130	0	0	90.06
90.07	04951	ONCOLOGY	0.542899	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.209065	0	0	90.08
91.00	09100	EMERGENCY	0.140227	23,996	3,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.628478	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		268,196	60,257	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)		268,196		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 10:15 am

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		434,754		30.00
31.00	03100	INTENSIVE CARE UNIT		328,427		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.378470	314,758	119,126	50.00
51.00	05100	RECOVERY ROOM	0.532107	28,538	15,185	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153974	76,355	11,757	54.00
60.00	06000	LABORATORY	0.165187	205,542	33,953	60.00
65.00	06500	RESPIRATORY THERAPY	0.352663	103,697	36,570	65.00
66.00	06600	PHYSICAL THERAPY	0.560561	8,159	4,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455102	6,807	3,098	67.00
68.00	06800	SPEECH PATHOLOGY	0.481562	3,031	1,460	68.00
69.00	06900	ELECTROCARDIOLOGY	0.168900	74,790	12,632	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.038317	14,162	543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.404443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262560	289,534	76,020	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.535896	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.289107	197	57	90.01
90.02	09002	DIABETES CLINIC	2.042989	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	16.194974	0	0	90.04
90.05	09005	PRIME TIME	0.139774	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	302.370130	0	0	90.06
90.07	04951	ONCOLOGY	0.542899	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.209065	0	0	90.08
91.00	09100	EMERGENCY	0.140227	95,975	13,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.628478	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,221,545	328,433	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)		1,221,545		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,914,302	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,122,722	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)	9,158	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	10,024	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	72.33	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.58	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.62	31.00
32.00	Sum of lines 30 and 31	19.20	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.23	33.00
34.00	Disproportionate share adjustment (see instructions)	92,010	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,131,355	1,619,884	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	846,971	408,300	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,255,271		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)	8,403,487		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	8,403,487	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	547,901	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	37,359	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)	10,665	58.00
59.00	Total (sum of amounts on lines 49 through 58)	8,999,412	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	8,999,412	61.00
62.00	Deductibles billed to program beneficiaries	897,952	62.00
63.00	Coinsurance billed to program beneficiaries	7,722	63.00
64.00	Allowable bad debts (see instructions)	38,400	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	24,960	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,192	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,118,698	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	54,617	70.93
70.94	HRR adjustment amount (see instructions)	-10,969	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	665,743	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	264,355	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		63,785	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,028,659	71.00
71.01	Sequestration adjustment (see instructions)		59,589	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		8,681,117	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)		287,953	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		174,889	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,914,302	0	4,914,302		4,914,302	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,122,722	0		2,122,722	2,122,722	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	9,158	0	9,158		9,158	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	10,024	0		10,024	10,024	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	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	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0523	0.0523	0.0523	0.0523		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	92,010	0	64,255	27,755	92,010	11.00
11.01	Uncompensated care payments	36.00	1,255,271	0	846,971	408,300	1,255,271	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	8,403,487	0	5,834,686	2,568,801	8,403,487	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,403,487	0	5,834,686	2,568,801	8,403,487	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	547,901	0	389,015	158,886	547,901	16.00
17.00	Special add-on payments for new technologies	54.00	37,359	0	0	37,359	37,359	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	6,223,701	2,765,046	8,988,747	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	544,435	0	387,324	157,111	544,435	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	3,466	0	1,691	1,775	3,466	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	547,901	0	389,015	158,886	547,901	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				0.106969	0.095606		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			665,743		665,743	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				264,355	264,355	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/29/2021 10:15 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,914,302	4,914,302		4,914,302	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,122,722		2,122,722	2,122,722	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	9,158	9,158		9,158	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	10,024		10,024	10,024	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0523	0.0523	0.0523		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	92,010	64,255	27,755	92,010	11.00
11.01	Uncompensated care payments	36.00	1,255,271	846,971	408,300	1,255,271	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	8,403,487	5,834,686	2,568,801	8,403,487	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,403,487	5,834,686	2,568,801	8,403,487	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	547,901	-151,954	699,855	547,901	16.00
17.00	Special add-on payments for new technologies	54.00	37,359	0	37,359	37,359	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			5,682,732	3,306,015	8,988,747	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/29/2021 10:15 am

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		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	544,435	-157,111	701,546	544,435	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	3,466	5,157	-1,691	3,466	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	547,901	-151,954	699,855	547,901	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	665,743	665,743		665,743	28.00
29.00	Low volume adjustment on or after October 1	70.97	264,355		264,355	264,355	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	54,617	40,309	14,308	54,617	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-10,969	-10,320	-649	-10,969	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		63,785	0	63,785	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,104	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	18,136,189	2.00
3.00	OPPS payments	12,083,304	3.00
4.00	Outlier payment (see instructions)	41,133	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	76,218	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,104	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	8,014	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)	8,014	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)	8,014	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,910	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)	2,104	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)	12,200,655	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)	2,065,849	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)	10,136,910	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)	10,136,910	30.00
31.00	Primary payer payments	4,972	31.00
32.00	Subtotal (line 30 minus line 31)	10,131,938	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)	143,897	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	93,533	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	111,293	36.00
37.00	Subtotal (see instructions)	10,225,471	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-2	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)	10,225,473	40.00
40.01	Sequestration adjustment (see instructions)	67,488	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	10,214,917	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)	-56,932	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/29/2021 10:15 am

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		8,627,977		9,992,938	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	53,140	12/31/2020	194,979	3.01
3.02			0	03/04/2020	27,000	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)		53,140		221,979	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)		8,681,117		10,214,917	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		287,953		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		56,932	6.02
7.00	Total Medicare program liability (see instructions)		8,969,070		10,157,985	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: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/29/2021 10:15 am

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		478,102		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		478,102		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		6,671		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		484,773		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/29/2021 10:15 am
	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: 15-0037 Component CCN: 15-S037	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/29/2021 10:15 am
	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)	517,163	1.00
2.00	Net IPF PPS Outlier Payments	0	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)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	1.516393	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	517,163	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)	517,163	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	517,163	18.00
19.00	Deductibles	29,304	19.00
20.00	Subtotal (line 18 minus line 19)	487,859	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	487,859	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	487,859	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	135	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)	487,994	31.00
31.01	Sequestration adjustment (see instructions)	3,221	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	478,102	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)	6,671	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	0	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: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII | Date/Time Prepared: 7/29/2021 10:15 am

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	767,350		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)	767,350	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)	767,350	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	763,181		8.00
9.00	Ancillary service charges	1,221,545	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)	1,984,726	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)	1,984,726	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,217,376	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)	767,350	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)	767,350	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)	767,350	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)	767,350	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	767,350	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)	767,350	0	40.00
41.00	Interim payments	899,533	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-132,183	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/29/2021 10:15 am

		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	12,490,827	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	16,212,672	0	0	0	4.00
5.00	Other receivable	23,870,934	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,971,939	0	0	0	7.00
8.00	Prepaid expenses	2,615,814	0	0	0	8.00
9.00	Other current assets	111,552,296	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)	170,714,482	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	24,498,402	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	163,766,689	0	0	0	15.00
16.00	Accumulated depreciation	-166,300,575	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	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	93,664,019	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	115,628,535	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	37,518,615	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	37,518,615	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	323,861,632	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,320,123	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,314,708	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	19,055,542	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,690,373	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	35,690,373	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	288,171,259				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)	288,171,259	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	323,861,632	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/29/2021 10:15 am

		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		282,337,023		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,834,236				2.00
3.00	Total (sum of line 1 and line 2)		288,171,259		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		288,171,259		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)		288,171,259		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/29/2021 10:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,241,354		6,241,354	1.00
2.00	SUBPROVIDER - IPF	-770,026		-770,026	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,471,328		5,471,328	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,614,111		11,614,111	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)	11,614,111		11,614,111	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,085,439		17,085,439	17.00
18.00	Ancillary services	40,898,962	316,645,939	357,544,901	18.00
19.00	Outpatient services	0	24,024	24,024	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	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	902,219	621,133	1,523,352	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	58,886,620	317,291,096	376,177,716	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		151,967,680		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)		151,967,680		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/29/2021 10:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	376,177,716	1.00
2.00	Less contractual allowances and discounts on patients' accounts	249,509,750	2.00
3.00	Net patient revenues (line 1 minus line 2)	126,667,966	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	151,967,680	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-25,299,714	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	15,308,799	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	7,849,867	24.00
24.01	OTHER NON-OPERATING INCOME	3,650,512	24.01
24.50	COVID-19 PHE Funding	5,049,561	24.50
25.00	Total other income (sum of lines 6-24)	31,858,739	25.00
26.00	Total (line 5 plus line 25)	6,559,025	26.00
27.00	OTHER EXPENSE-GAIN/LOSS	724,789	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	724,789	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,834,236	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	544,435	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,466	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)	24.26	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	547,901	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/29/2021 10:15 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	26,968	0	26,968	0	26,968	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	134,223	0	134,223	0	134,223	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	69,702	0	69,702	0	69,702	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	23,644	0	23,644	0	23,644	9.00
10.00	Subtotal (sum of lines 1 through 9)	254,537	0	254,537	0	254,537	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	1,764	1,764	0	1,764	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,764	1,764	0	1,764	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	254,537	1,764	256,301	0	256,301	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	32,161	32,161	-30,907	1,254	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	32,161	32,161	-30,907	1,254	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	205,214	205,214	0	205,214	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	205,214	205,214	0	205,214	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	254,537	239,139	493,676	-30,907	462,769	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/29/2021 10:15 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	26,968		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	134,223		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	69,702		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	23,644		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	254,537		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	1,764		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,764		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	256,301		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	1,254		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,254		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	205,214		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	205,214		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	462,769		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/29/2021 10:15 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Cost: Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.18	22	4,200	756		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.92	3,444	2,100	1,932		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.10	3,466		2,688	3,466	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.10	3,466			3,466	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					256,301	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,254	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					257,555	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995131	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					205,214	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					148,678	15.00
16.00	Total overhead (sum of lines 14 and 15)					353,892	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					353,892	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					352,169	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					608,470	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			608,470	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			34,245	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			574,225	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,466	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,466	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			165.67	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	86.31		8.00
9.00	Rate for Program covered visits (see instructions)	86.31	86.31		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	266		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	22,958		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	22,958		16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,898		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,680		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,352		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		10,639		16.04
16.05	Total program cost (see instructions)	0	13,991		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,307		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,268		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,991		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,998		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		34,989		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		34,989		26.00
26.01	Sequestration adjustment (see instructions)		231		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		13,111		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		21,647		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/29/2021 10:15 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	254,537	254,537	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003266	0.025998	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	831	6,617	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,068	2,909	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,899	9,526	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	256,301	256,301	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	352,169	352,169	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019114	0.037167	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,731	13,089	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	11,630	22,615	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	25	199	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	465.20	113.64	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	107	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,839	12,159	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		34,245	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		20,998	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/29/2021 10:15 am

		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		13,111	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		13,111	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		21,647	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		34,758	7.00

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