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: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 2:11 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/2/2021 Time: 2:11 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MAJOR HOSPITAL (15-0097) 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) RALPH MERCURI
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	274,459	-6,803	0	-220,752	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		2,108		0	10.00
10.01	RURAL HEALTH CLINIC II	0		25,456		0	10.01
10.02	RURAL HEALTH CLINIC III	0		1,017,657		0	10.02
200.00	Total	0	274,459	1,038,418	0	-220,752	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2451 INTELLIPLEX DR	PO Box:			1.00
2.00	City: SHELBYVILLE	State: IN	Zip Code: 46176-	County: SHELBY	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	MAJOR HOSPITAL	150097	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MAJOR HOSPITAL	157418	99915		03/22/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MHP PEDIATRICS	158529	99915		01/29/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MHP OB/GYN	158531	99915		01/29/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MHP FAMILY & INTERNAL MEDICINE	158532	99915		01/29/2018	N	N	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	329	586	0	0	1,247	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)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

				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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 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.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	328,216	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 8/2/2021 2:11 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 2:11 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 2:11 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR 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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 8/2/2021 2:11 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	12	14,640	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)		12	14,640	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	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)		18	16,836	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,102	326	8,327			1.00
2.00	HMO and other (see instructions)	2,214	1,787				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,102	326	8,327			7.00
8.00	INTENSIVE CARE UNIT	567	0	1,611			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)	3,669	326	9,938	0.00	657.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	5,242	234	8,795	0.00	12.82	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	45	9,533	17,751	0.00	20.89	26.00
26.01	RURAL HEALTH CLINIC II	235	835	6,366	0.00	13.06	26.01
26.02	RURAL HEALTH CLINIC III	12,135	2,293	46,816	0.00	79.83	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	784.47	27.00
28.00	Observation Bed Days		74	734			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	49	87			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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,015	72	2,687	1.00
2.00	HMO and other (see instructions)			555	505		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,015	72	2,687	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 2:11 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	55,061,856	0	55,061,856	1,631,704.00	33.75	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		554,914	0	554,914	2,912.00	190.56	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		2,264,073	0	2,264,073	12,055.00	187.81	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		5,415,153	0	5,415,153	236,680.00	22.88	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)		3,819,530	70,131	3,889,661	71,573.00	54.35	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		225,853	0	225,853	4,117.00	54.86	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		316,323	0	316,323	1,379.00	229.39	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)		10,948,308	0	10,948,308			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		761,594	0	761,594			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		51,946	0	51,946			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		213,551	0	213,551			23.00
24.00	Wage-related costs (RHC/FQHC)		1,704,288	0	1,704,288			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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 2:11 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	440,180	0	440,180	11,872.00	37.08	26.00
27.00	Administrative & General	5.00	8,952,213	-127,547	8,824,666	242,545.00	36.38	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,229,127	0	1,229,127	44,666.00	27.52	30.00
31.00	Laundry & Linen Service	8.00	100,557	0	100,557	4,994.00	20.14	31.00
32.00	Housekeeping	9.00	1,454,502	0	1,454,502	79,036.00	18.40	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	682,383	-541,812	140,571	8,224.00	17.09	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	541,812	541,812	32,593.00	16.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,614,387	0	1,614,387	41,009.00	39.37	38.00
39.00	Central Services and Supply	14.00	262,039	-262,039	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,156,987	0	1,156,987	25,591.00	45.21	40.00
41.00	Medical Records & Medical Records Library	16.00	1,358,816	0	1,358,816	55,778.00	24.36	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 8/2/2021 2:11 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		47,382,630	0	47,382,630	1,382,969.00	34.26	1.00
2.00	Excluded area salaries (see instructions)		3,819,530	70,131	3,889,661	71,573.00	54.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)		43,563,100	-70,131	43,492,969	1,311,396.00	33.17	3.00
4.00	Subtotal other wages & related costs (see inst.)		542,176	0	542,176	5,496.00	98.65	4.00
5.00	Subtotal wage-related costs (see inst.)		11,000,254	0	11,000,254	0.00	25.29	5.00
6.00	Total (sum of lines 3 thru 5)		55,105,530	-70,131	55,035,399	1,316,892.00	41.79	6.00
7.00	Total overhead cost (see instructions)		17,251,191	-389,586	16,861,605	546,308.00	30.86	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 2:11 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,184,500	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)	7,109,146	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	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	48,268	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	95,082	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)	201,538	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	92,280	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	3,787,117	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	157,090	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	4,667	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,679,688	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	225,853	13,679,688	1.00
2.00	Hospital	225,853	13,679,688	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-4 | Date/Time Prepared: 8/2/2021 2:11 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,204	29	735	2,968	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	179.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.29	0.00	2.29	5.00
6.00	Direct Nursing Service			7.11	0.00	7.11	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.65	0.00	2.65	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.26	0.00	1.26	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.43	0.00	1.43	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			26900			20.00
20.01				99915			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,633	601	46	76	2,356	21.00
22.00	Skilled Nursing Visit Charges	405,958	146,772	13,594	19,008	585,332	22.00
23.00	Physical Therapy Visits	1,047	542	6	60	1,655	23.00
24.00	Physical Therapy Visit Charges	235,560	119,780	1,500	13,200	370,040	24.00
25.00	Occupational Therapy Visits	313	396	4	20	733	25.00
26.00	Occupational Therapy Visit Charges	68,860	87,120	880	4,400	161,260	26.00
27.00	Speech Pathology Visits	5	10	0	0	15	27.00
28.00	Speech Pathology Visit Charges	1,100	2,200	0	0	3,300	28.00
29.00	Medical Social Service Visits	15	11	0	1	27	29.00
30.00	Medical Social Service Visit Charges	3,300	2,420	0	220	5,940	30.00
31.00	Home Health Aide Visits	239	207	0	10	456	31.00
32.00	Home Health Aide Visit Charges	26,768	23,184	0	1,120	51,072	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,252	1,767	56	167	5,242	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	741,546	381,476	15,974	37,948	1,176,944	35.00
36.00	Total Number of Episodes (standard/non outlier)	284		32	14	330	36.00
37.00	Total Number of Outlier Episodes		71		4	75	37.00
38.00	Total Non-Routine Medical Supply Charges	161,352	57,924	1,379	7,137	227,792	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC I

				1.00		
	Clinic Address and Identification					
1.00	Street			2451 INTELLIPLEX DRIVE, SUITE 240		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IN	46176	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		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			07:30	17:00	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		SHELBY				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	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC I

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC II

					1.00	
	Clinic Address and Identification					
1.00	Street				2451 INTELLIPLEX DRIVE, SUITE 230	1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IN	46176	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		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?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		SHELBY				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: 15-0097 Component CCN: 15-8531	Period: From 01/01/2020 To 12/31/2020	Worksheet S-8 Date/Time Prepared: 8/2/2021 2:11 pm

RHC II

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC III

				1.00		
	Clinic Address and Identification					
1.00	Street			2451 INTELLIPLEX DRIVE, SUITE 260		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IN	46176	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		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			07:00	17:00	07:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		SHLEBY				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	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC III

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 8/2/2021 2:11 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.294515	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,221,788	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	61,739,213	6.00
7.00	Medicaid cost (line 1 times line 6)	18,183,124	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)	10,961,336	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)	10,961,336	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,569,172	1,851,552	9,420,724	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,229,235	1,851,552	4,080,787	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)	2,229,235	1,851,552	4,080,787	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)	9,573,494	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	278,375	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	428,270	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,145,224	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,843,301	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,924,088	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,885,424	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		11,564,131	11,564,131	0	11,564,131	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	440,180	10,217,370	10,657,550	0	10,657,550	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,952,213	22,947,598	31,899,811	-279,966	31,619,845	5.00
7.00	00700	OPERATION OF PLANT	1,229,127	1,814,673	3,043,800	0	3,043,800	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100,557	309,366	409,923	0	409,923	8.00
9.00	00900	HOUSEKEEPING	1,454,502	846,234	2,300,736	0	2,300,736	9.00
10.00	01000	DIETARY	682,383	955,282	1,637,665	-1,300,306	337,359	10.00
11.00	01100	CAFETERIA	0	0	0	1,300,306	1,300,306	11.00
13.00	01300	NURSING ADMINISTRATION	1,614,387	631,630	2,246,017	0	2,246,017	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	262,039	502,627	764,666	-764,666	0	14.00
15.00	01500	PHARMACY	1,156,987	10,861,536	12,018,523	0	12,018,523	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,358,816	508,016	1,866,832	0	1,866,832	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,808,989	1,517,379	7,326,368	21,052	7,347,420	30.00
31.00	03100	INTENSIVE CARE UNIT	1,711,330	464,459	2,175,789	0	2,175,789	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,372,266	4,122,945	6,495,211	-1,352,607	5,142,604	50.00
53.00	05300	ANESTHESIOLOGY	2,908,543	252,221	3,160,764	0	3,160,764	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,862,557	3,319,698	6,182,255	0	6,182,255	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	1,341,799	1,404,950	2,746,749	0	2,746,749	56.01
57.00	05700	CT SCAN	308,339	541,743	850,082	0	850,082	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	370,559	482,475	853,034	0	853,034	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,118,426	4,267,430	6,385,856	0	6,385,856	60.00
65.00	06500	RESPIRATORY THERAPY	1,105,824	232,301	1,338,125	0	1,338,125	65.00
65.01	06501	SLEEP LAB	430,362	157,834	588,196	0	588,196	65.01
66.00	06600	PHYSICAL THERAPY	1,689,756	238,455	1,928,211	0	1,928,211	66.00
69.00	06900	ELECTROCARDIOLOGY	702,164	1,585,404	2,287,568	0	2,287,568	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,775,682	1,775,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	921,880	1,417,274	2,339,154	57,416	2,396,570	88.00
88.01	08801	RURAL HEALTH CLINIC II	607,554	1,148,390	1,755,944	0	1,755,944	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,828,303	4,720,071	8,548,374	0	8,548,374	88.02
90.00	09000	CLINIC	1,259,043	1,107,639	2,366,682	0	2,366,682	90.00
91.00	09100	EMERGENCY	2,405,785	1,519,309	3,925,094	320,539	4,245,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,237,656	364,755	1,602,411	0	1,602,411	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	870,601	186,585	1,057,186	0	1,057,186	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,112,927	90,209,780	142,322,707	-222,550	142,100,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	UROLOGY	849	4,598	5,447	0	5,447	190.01
190.05	19005	MARKETING	0	0	0	279,966	279,966	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	66,122	74,591	140,713	0	140,713	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	4,890	28,296	33,186	0	33,186	190.09
190.11	19011	MHP ADMIN BUILDING	31,063	42,035	73,098	0	73,098	190.11
190.16	19016	RENOVO	88,650	83,943	172,593	0	172,593	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	-131	-131	0	-131	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	2,567,978	411,561	2,979,539	-57,416	2,922,123	192.01
194.00	07950	UNAVIE	189,377	45,331	234,708	0	234,708	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	55,061,856	90,900,004	145,961,860	0	145,961,860	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,714,004	9,850,127		1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,953	10,646,597		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,448,837	20,171,008		5.00
7.00	00700	OPERATION OF PLANT	0	3,043,800		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	409,923		8.00
9.00	00900	HOUSEKEEPING	-1,252	2,299,484		9.00
10.00	01000	DIETARY	-26,099	311,260		10.00
11.00	01100	CAFETERIA	-338,433	961,873		11.00
13.00	01300	NURSING ADMINISTRATION	-33,831	2,212,186		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-18,947	11,999,576		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,866,832		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-5,947	7,341,473		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,175,789		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-99,332	5,043,272		50.00
53.00	05300	ANESTHESIOLOGY	-2,934,511	226,253		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,000,133	5,182,122		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	-236,252	2,510,497		56.01
57.00	05700	CT SCAN	-4,668	845,414		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	853,034		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-114,320	6,271,536		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,338,125		65.00
65.01	06501	SLEEP LAB	0	588,196		65.01
66.00	06600	PHYSICAL THERAPY	-73,242	1,854,969		66.00
69.00	06900	ELECTROCARDIOLOGY	-82,168	2,205,400		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,775,682		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	943,000	3,339,570		88.00
88.01	08801	RURAL HEALTH CLINIC II	64,624	1,820,568		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,203,637	10,752,011		88.02
90.00	09000	CLINIC	-787,524	1,579,158		90.00
91.00	09100	EMERGENCY	-804,127	3,441,506		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	1,602,411		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	-1,836	1,055,350		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,525,155	125,575,002		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	UROLOGY	0	5,447		190.01
190.05	19005	MARKETING	0	279,966		190.05
190.07	19007	I-74 CAMPUS	0	0		190.07
190.08	19008	RAMPART	0	140,713		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	33,186		190.09
190.11	19011	MHP ADMIN BUILDING	0	73,098		190.11
190.16	19016	RENOVO	0	172,593		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	-131		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	2,922,123		192.01
194.00	07950	UNAVIE	0	234,708		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,525,155	129,436,705		200.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 2:11 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	541,812	758,494		1.00
	0		541,812	758,494		
	B - CS&R OTHER					
1.00	ADULTS & PEDIATRICS	30.00	7,214	13,838		1.00
2.00	OPERATING ROOM	50.00	144,981	278,094		2.00
3.00	EMERGENCY	91.00	109,844	210,695		3.00
	0		262,039	502,627		
	C - MARKETING					
1.00	MARKETING	190.05	127,547	152,419		1.00
	0		127,547	152,419		
	D - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	101,941	1,673,741		1.00
	0		101,941	1,673,741		
	E - RHC RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	57,416	0		1.00
	0		57,416	0		
500.00	Grand Total: Increases		1,090,755	3,087,281		500.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 2:11 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	541,812	758,494	0		1.00
	0		541,812	758,494			
	B - CS&R OTHER						
1.00	CENTRAL SERVICES & SUPPLY	14.00	262,039	502,627	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		262,039	502,627			
	C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	127,547	152,419	0		1.00
	0		127,547	152,419			
	D - IMPLANTABLE DEVICES RECLASS						
1.00	OPERATING ROOM	50.00	101,941	1,673,741	0		1.00
	0		101,941	1,673,741			
	E - RHC RECLASS						
1.00	HOSPITALIST	192.01	57,416	0	0		1.00
	0		57,416	0			
500.00	Grand Total: Decreases		1,090,755	3,087,281			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,900,662	0	0	0	0	1.00
2.00	Land Improvements	12,298,052	0	0	0	0	2.00
3.00	Buildings and Fixtures	116,771,310	12,132,174	0	12,132,174	0	3.00
4.00	Building Improvements	0	268,012	0	268,012	0	4.00
5.00	Fixed Equipment	6,969,171	0	0	0	2,318,935	5.00
6.00	Movable Equipment	61,546,259	1,316,471	0	1,316,471	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	200,485,454	13,716,657	0	13,716,657	2,318,935	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	200,485,454	13,716,657	0	13,716,657	2,318,935	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,900,662	0	1.00
2.00	Land Improvements	12,298,052	0	2.00
3.00	Buildings and Fixtures	128,903,484	0	3.00
4.00	Building Improvements	268,012	0	4.00
5.00	Fixed Equipment	4,650,236	0	5.00
6.00	Movable Equipment	62,862,730	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	211,883,176	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	211,883,176	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	11,564,131	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	11,564,131	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	11,564,131		1.00
3.00	Total (sum of lines 1-2)	0	11,564,131		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	211,883,176	0	211,883,176	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	211,883,176	0	211,883,176	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,546,131	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	11,546,131	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-1,696,004	0	0	0	9,850,127	1.00
3.00	Total (sum of lines 1-2)	-1,696,004	0	0	0	9,850,127	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,696,004	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	A	-3,727	ADMINISTRATIVE & GENERAL	5.00	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	-5,823,201			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	3,238,818			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-338,433	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
34.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.01
35.00	MAJ OTHER REVENUES RENTAL INCOME	B	-18,000	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	MAJ TECHNOLOGY SERV CONTRACT LABOR	B	-157,277	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MAJ PATIENT ACCESS CONTRACT LABOR	B	-5,732	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MAJ ACCOUNTING CONTRACT LABOR	B	-132,946	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	MAJ ADMINISTRATION CONTRACT LABOR	B	-231,777	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MH EDUCATION CLASS REVENUE	B	26,760	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MAJ ACCOUNTING VENDOR REBATES	B	-21,593	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	MAJ OTHER REVENUES PURCHASE DISCOUNT	B	-2,089	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MAJ OTHER REVENUES REAPPOINTMENT FEE	B	4,473	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MAJ PATIENT FINANCI PHYSICIAN BILLIN	B	-532,255	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MAJ ENVIRONMENTAL S OTHER INCOME	B	-1,252	HOUSEKEEPING	9.00	0	45.02
45.03	MAJ FOOD AND NUTRIT OTHER CAFETERIA	B	0	CAFETERIA	11.00	0	45.03
45.04	MAJ PHARMACY VENDOR REBATES	B	-18,947	PHARMACY	15.00	0	45.04
45.05	MAJ OTHER REVENUES XEROX AND COPYING	B	0	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MAJ INPATIENT-AMU OTHER INCOME	B	0	ADULTS & PEDIATRICS	30.00	0	45.06
45.07	MAJ RESPIRATORY CAR VENDOR REBATES	B	0	RESPIRATORY THERAPY	65.00	0	45.07
45.08	MAJ REHABILATION SE CONTRACT LABOR	B	-64,968	PHYSICAL THERAPY	66.00	0	45.08
45.09	MAJ CARDIAC DISEASE CONTRACT LABOR	B	-61,992	ELECTROCARDIOLOGY	69.00	0	45.09
45.10	MAJ CENTRAL SUPPLY VENDOR REBATES	B	-4,332	OPERATING ROOM	50.00	0	45.10
45.11	MH MHP FIM OTHER INCOME	B	-670	RURAL HEALTH CLINIC III	88.02	0	45.11
45.12	MAJ DISEASE MGT CLASS REVENUE	B	-1,750	CLINIC	90.00	0	45.12
45.13	MAJ MEDICAL SPECIAL RENTAL INCOME	B	-204,675	CLINIC	90.00	0	45.13
45.14	MAJ ONSITE SOLUTION OTHER INCOME	B	-1,148	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	MAJ OTHER REVENUES OTHER INCOME	B	-23,294	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	MAJ HOME HEALTH OTHER DISCOUNT	B	-1,747	HOME HEALTH AGENCY	101.00	0	45.16
45.17	MEALS ON WHEELS	A	-26,099	DIETARY	10.00	0	45.17
45.18	PROMOTIONAL GIFTS	A	-12,166	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	PROMOTIONAL GIFTS	A	-284	NURSING ADMINISTRATION	13.00	0	45.19
45.20	PROMOTIONAL GIFTS	A	-5,947	ADULTS & PEDIATRICS	30.00	0	45.20
45.21	PROMOTIONAL GIFTS	A	-496	RADIOLOGY-DIAGNOSTIC	54.00	0	45.21
45.22	PROMOTIONAL GIFTS	A	-3,847	ONCOLOGY	56.01	0	45.22
45.23	PROMOTIONAL GIFTS	A	-4,137	PHYSICAL THERAPY	66.00	0	45.23
45.24	PROMOTIONAL GIFTS	A	-140	RURAL HEALTH CLINIC	88.00	0	45.24
45.25	PROMOTIONAL GIFTS	A	0	RURAL HEALTH CLINIC II	88.01	0	45.25
45.26	PROMOTIONAL GIFTS	A	-263	CLINIC	90.00	0	45.26
45.27	MAJ MAJOR PEDIATRIC ADVERTISING	A	0	RURAL HEALTH CLINIC	88.00	0	45.27

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
45.28	MAJ WOUND CARE ADVERTISING	A	-139	CLINIC	90.00	0	45.28
45.29	MAJ HOME HEALTH ADVERTISING	A	-89	HOME HEALTH AGENCY	101.00	0	45.29
45.30	MAJ MHP FIM ADVERTISING	A	-1,500	RURAL HEALTH CLINIC III	88.02	0	45.30
45.31	MAJ COMMUNITY OUTRE ADVERTISING	A	-9,374	ADMINISTRATIVE & GENERAL	5.00	0	45.31
45.32	MAJ MARKETING ADVERTISING	A	-14,928	ADMINISTRATIVE & GENERAL	5.00	0	45.32
45.33	MAJ HUMAN RESOURCES ADVERTISING	A	-6,899	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.33
45.34	MAJ MHP FIM OP/OTHER	B	127	RURAL HEALTH CLINIC III	88.02	0	45.34
45.35	MAJ REHABILATION SE ADVERTISING-SPOR	A	-4,137	PHYSICAL THERAPY	66.00	0	45.35
45.36	MAJ HUMAN RESOURCES ADVERTISING	A	-255	RURAL HEALTH CLINIC II	88.01	0	45.36
45.37	COMMUNITY OUTREACH	A	-353,854	ADMINISTRATIVE & GENERAL	5.00	0	45.37
45.38	HAF EXPENSE	A	-4,737,826	ADMINISTRATIVE & GENERAL	5.00	0	45.38
45.39	NON-ALLOWABLE RHC	A	-25,119	RURAL HEALTH CLINIC II	88.01	0	45.39
45.40	LOBBYING % OF DUES	A	-8,271	ADMINISTRATIVE & GENERAL	5.00	0	45.40
45.41	MISC PURCHASED SERVICES	A	-5,231,754	ADMINISTRATIVE & GENERAL	5.00	0	45.41
45.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.42
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,525,155				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 2:11 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	88.00	RURAL HEALTH CLINIC	MHP PEDS RHC	1,749,717	806,577	1.00
2.00	88.01	RURAL HEALTH CLINIC II	MHP OBGYN RHC	818,532	728,534	2.00
3.00	88.02	RURAL HEALTH CLINIC III	MHP FIM RHC	5,156,478	2,950,798	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,724,727	4,485,909	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 8/2/2021 2:11 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	943,140	0		1.00
2.00	89,998	0		2.00
3.00	2,205,680	0		3.00
4.00	0	0		4.00
5.00	3,238,818			5.00

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

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

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

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

6.00	PHYSICIAN GROUP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 8/2/2021 2:11 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	29,011	0	29,011	179,000	290	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	403	0	403	179,000	4	2.00
3.00	13.00	NURSING ADMINISTRATION	33,547	33,547	0	0	0	3.00
4.00	50.00	OPERATING ROOM	95,000	95,000	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	3,269,671	2,616,887	652,784	239,400	2,912	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	999,637	999,637	0	0	0	6.00
7.00	56.01	ONCOLOGY	252,013	227,013	25,000	271,900	150	7.00
8.00	57.00	CT SCAN	4,668	4,668	0	0	0	8.00
9.00	60.00	LABORATORY	135,469	0	135,469	260,300	169	9.00
10.00	69.00	ELECTROCARDIOLOGY	20,176	20,176	0	0	0	10.00
11.00	90.00	CLINIC	603,244	556,704	46,540	179,000	262	11.00
12.00	91.00	EMERGENCY	847,500	785,000	62,500	179,000	504	12.00
200.00			6,290,339	5,338,632	951,707		4,291	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	24,957	1,248	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	344	17	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	335,160	16,758	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	56.01	ONCOLOGY	19,608	980	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	21,149	1,057	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	22,547	1,127	0	0	0	11.00
12.00	91.00	EMERGENCY	43,373	2,169	0	0	0	12.00
200.00			467,138	23,356	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	24,957	4,054	4,054		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	344	59	59		2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	33,547		3.00
4.00	50.00	OPERATING ROOM	0	0	0	95,000		4.00
5.00	53.00	ANESTHESIOLOGY	0	335,160	317,624	2,934,511		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	999,637		6.00
7.00	56.01	ONCOLOGY	0	19,608	5,392	232,405		7.00
8.00	57.00	CT SCAN	0	0	0	4,668		8.00
9.00	60.00	LABORATORY	0	21,149	114,320	114,320		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,176		10.00
11.00	90.00	CLINIC	0	22,547	23,993	580,697		11.00
12.00	91.00	EMERGENCY	0	43,373	19,127	804,127		12.00
200.00			0	467,138	484,569	5,823,201		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,850,127	9,850,127				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,646,597	38,841	10,685,438			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,171,008	805,565	1,989,258	22,965,831	22,965,831	5.00
7.00	00700	OPERATION OF PLANT	3,043,800	504,604	250,875	3,799,279	819,504	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	409,923	43,808	20,524	474,255	102,297	8.00
9.00	00900	HOUSEKEEPING	2,299,484	87,119	296,875	2,683,478	578,826	9.00
10.00	01000	DIETARY	311,260	53,477	28,692	393,429	84,863	10.00
11.00	01100	CAFETERIA	961,873	189,736	110,588	1,262,197	272,256	11.00
13.00	01300	NURSING ADMINISTRATION	2,212,186	86,325	135,621	2,434,132	525,042	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107,186	0	107,186	23,120	14.00
15.00	01500	PHARMACY	11,999,576	102,351	236,150	12,338,077	2,661,357	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,866,832	74,007	277,345	2,218,184	478,462	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,341,473	868,314	1,187,134	9,396,921	2,026,916	30.00
31.00	03100	INTENSIVE CARE UNIT	2,175,789	136,358	349,296	2,661,443	574,073	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,043,272	931,263	492,983	6,467,518	1,395,044	50.00
53.00	05300	ANESTHESIOLOGY	226,253	16,589	140,607	383,449	82,710	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,182,122	305,961	584,271	6,072,354	1,309,807	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	2,510,497	660,068	273,872	3,444,437	742,965	56.01
57.00	05700	CT SCAN	845,414	69,172	62,934	977,520	210,851	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	853,034	69,768	75,634	998,436	215,363	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,271,536	190,530	432,388	6,894,454	1,487,134	60.00
65.00	06500	RESPIRATORY THERAPY	1,338,125	152,517	225,708	1,716,350	370,217	65.00
65.01	06501	SLEEP LAB	588,196	0	87,840	676,036	145,821	65.01
66.00	06600	PHYSICAL THERAPY	1,854,969	390,961	344,893	2,590,823	558,841	66.00
69.00	06900	ELECTROCARDIOLOGY	2,205,400	40,397	140,072	2,385,869	514,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,775,682	0	20,807	1,796,489	387,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,339,570	242,385	199,882	3,781,837	815,742	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,820,568	143,212	124,007	2,087,787	450,336	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,752,011	799,042	781,387	12,332,440	2,660,107	88.02
90.00	09000	CLINIC	1,579,158	406,293	256,981	2,242,432	483,693	90.00
91.00	09100	EMERGENCY	3,441,506	454,140	513,460	4,409,106	951,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,602,411	243,544	252,615	2,098,570	452,662	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,055,350	211,623	177,697	1,444,670	311,615	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,575,002	8,425,156	10,070,396	123,534,989	21,692,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,868	0	24,868	5,364	190.00
190.01	19001	UROLOGY	5,447	0	0	5,447	1,175	190.01
190.05	19005	MARKETING	279,966	26,490	26,033	332,489	71,718	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	140,713	364,339	13,496	518,548	111,851	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	33,186	295,597	0	328,783	70,918	190.09
190.11	19011	MHP ADMIN BUILDING	73,098	92,715	6,340	172,153	37,133	190.11
190.16	19016	RENOVO	172,593	322,352	18,094	513,039	110,663	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	-131	0	0	-131	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	2,922,123	7,417	512,426	3,441,966	742,432	192.01
194.00	07950	UNAVIE	234,708	291,193	38,653	564,554	121,774	194.00
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)	129,436,705	9,850,127	10,685,438	129,436,705	22,965,831	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	4,618,783					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,802	600,354				8.00
9.00	00900	HOUSEKEEPING	47,333	0	3,309,637			9.00
10.00	01000	DIETARY	29,055	0	21,145	528,492		10.00
11.00	01100	CAFETERIA	103,086	0	75,023	0	1,712,562	11.00
13.00	01300	NURSING ADMINISTRATION	46,902	0	34,133	0	60,481	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,236	0	42,382	0	0	14.00
15.00	01500	PHARMACY	55,609	0	40,470	0	37,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,209	0	29,263	0	82,264	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	471,768	232,996	343,338	442,821	245,484	30.00
31.00	03100	INTENSIVE CARE UNIT	74,085	0	53,917	85,671	76,179	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	505,968	59,297	368,232	0	107,079	50.00
53.00	05300	ANESTHESIOLOGY	9,013	0	6,560	0	25,506	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	166,233	105,392	120,979	0	117,105	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	358,625	37,686	260,996	0	57,233	56.01
57.00	05700	CT SCAN	37,582	0	27,351	0	11,179	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,906	0	27,587	0	13,909	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	103,518	0	75,337	0	117,366	60.00
65.00	06500	RESPIRATORY THERAPY	82,865	14,984	60,306	0	47,073	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	212,415	19,063	154,589	0	62,581	66.00
69.00	06900	ELECTROCARDIOLOGY	21,949	0	15,973	0	22,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	131,691	0	95,841	0	64,091	88.00
88.01	08801	RURAL HEALTH CLINIC II	77,809	0	56,627	0	40,070	88.01
88.02	08802	RURAL HEALTH CLINIC III	434,131	0	315,947	0	244,908	88.02
90.00	09000	CLINIC	220,745	0	160,651	0	47,748	90.00
91.00	09100	EMERGENCY	246,741	130,936	179,571	0	114,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	132,321	0	96,299	0	49,514	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	114,978	0	83,677	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,844,575	600,354	2,746,194	528,492	1,651,982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,511	0	9,833	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	761	190.01
190.05	19005	MARKETING	14,392	0	10,474	0	5,324	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	197,951	0	144,062	0	5,905	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	160,602	0	116,881	0	370	190.09
190.11	19011	MHP ADMIN BUILDING	50,374	0	36,660	0	2,383	190.11
190.16	19016	RENOVO	175,139	0	127,460	0	6,939	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	4,030	0	2,933	0	38,898	192.01
194.00	07950	UNAVIE	158,209	0	115,140	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,618,783	600,354	3,309,637	528,492	1,712,562	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	3,100,690					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	230,924				14.00
15.00	01500	PHARMACY	0	0	15,133,256			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,848,382		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	602,776	0	0	100,873	13,863,893	30.00
31.00	03100	INTENSIVE CARE UNIT	187,055	0	0	46,262	3,758,685	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	262,928	127,008	0	473,170	9,766,244	50.00
53.00	05300	ANESTHESIOLOGY	62,629	0	0	3,619	573,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	200,398	8,092,268	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	140,534	0	0	159,285	5,201,761	56.01
57.00	05700	CT SCAN	0	0	0	212,521	1,477,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	69,336	1,362,537	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	313,518	8,991,327	60.00
65.00	06500	RESPIRATORY THERAPY	115,586	0	0	66,067	2,473,448	65.00
65.01	06501	SLEEP LAB	42,451	0	0	22,927	887,235	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	52,304	3,650,616	66.00
69.00	06900	ELECTROCARDIOLOGY	54,340	0	0	98,449	3,113,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	103,916	0	65,373	2,361,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	15,133,256	335,447	15,468,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	157,373	0	0	26,870	5,073,445	88.00
88.01	08801	RURAL HEALTH CLINIC II	98,391	0	0	19,003	2,830,023	88.01
88.02	08802	RURAL HEALTH CLINIC III	601,362	0	0	85,774	16,674,669	88.02
90.00	09000	CLINIC	117,244	0	0	35,571	3,308,084	90.00
91.00	09100	EMERGENCY	280,318	0	0	408,029	6,719,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	121,579	0	0	37,371	2,988,316	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	96,530	0	0	16,215	2,067,685	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,941,096	230,924	15,133,256	2,848,382	120,704,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	53,576	190.00
190.01	19001	UROLOGY	1,869	0	0	0	9,252	190.01
190.05	19005	MARKETING	0	0	0	0	434,397	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	14,500	0	0	0	992,817	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	909	0	0	0	678,463	190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	298,703	190.11
190.16	19016	RENOVO	17,039	0	0	0	950,279	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	-131	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	95,512	0	0	0	4,325,771	192.01
194.00	07950	UNAVIE	29,765	0	0	0	989,442	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,100,690	230,924	15,133,256	2,848,382	129,436,705	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,863,893		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,758,685		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,766,244		50.00
53.00	05300	ANESTHESIOLOGY	0	573,486		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,092,268		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	5,201,761		56.01
57.00	05700	CT SCAN	0	1,477,004		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,362,537		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	8,991,327		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,473,448		65.00
65.01	06501	SLEEP LAB	0	887,235		65.01
66.00	06600	PHYSICAL THERAPY	0	3,650,616		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,113,342		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,361,459		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,468,703		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	5,073,445		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,830,023		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	16,674,669		88.02
90.00	09000	CLINIC	0	3,308,084		90.00
91.00	09100	EMERGENCY	0	6,719,906		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,988,316		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	2,067,685		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	120,704,136		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,576		190.00
190.01	19001	UROLOGY	0	9,252		190.01
190.05	19005	MARKETING	0	434,397		190.05
190.07	19007	I-74 CAMPUS	0	0		190.07
190.08	19008	RAMPART	0	992,817		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	678,463		190.09
190.11	19011	MHP ADMIN BUILDING	0	298,703		190.11
190.16	19016	RENOVO	0	950,279		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	-131		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	4,325,771		192.01
194.00	07950	UNAVIE	0	989,442		194.00
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	129,436,705		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	38,841	38,841	38,841		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	805,565	805,565	7,225	812,790	5.00
7.00	00700	OPERATION OF PLANT	0	504,604	504,604	912	29,004	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,808	43,808	75	3,620	8.00
9.00	00900	HOUSEKEEPING	0	87,119	87,119	1,079	20,486	9.00
10.00	01000	DIETARY	0	53,477	53,477	104	3,003	10.00
11.00	01100	CAFETERIA	0	189,736	189,736	402	9,636	11.00
13.00	01300	NURSING ADMINISTRATION	0	86,325	86,325	493	18,582	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107,186	107,186	0	818	14.00
15.00	01500	PHARMACY	0	102,351	102,351	858	94,179	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,007	74,007	1,008	16,934	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	868,314	868,314	4,316	71,736	30.00
31.00	03100	INTENSIVE CARE UNIT	0	136,358	136,358	1,270	20,317	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	931,263	931,263	1,792	49,373	50.00
53.00	05300	ANESTHESIOLOGY	0	16,589	16,589	511	2,927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	305,961	305,961	2,124	46,356	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	660,068	660,068	996	26,295	56.01
57.00	05700	CT SCAN	0	69,172	69,172	229	7,462	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	69,768	69,768	275	7,622	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	190,530	190,530	1,572	52,632	60.00
65.00	06500	RESPIRATORY THERAPY	0	152,517	152,517	821	13,103	65.00
65.01	06501	SLEEP LAB	0	0	0	319	5,161	65.01
66.00	06600	PHYSICAL THERAPY	0	390,961	390,961	1,254	19,778	66.00
69.00	06900	ELECTROCARDIOLOGY	0	40,397	40,397	509	18,214	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	76	13,714	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	242,385	242,385	727	28,871	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	143,212	143,212	451	15,938	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	799,042	799,042	2,841	94,146	88.02
90.00	09000	CLINIC	0	406,293	406,293	934	17,119	90.00
91.00	09100	EMERGENCY	0	454,140	454,140	1,867	33,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	243,544	243,544	918	16,020	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	211,623	211,623	646	11,029	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,425,156	8,425,156	36,604	767,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,868	24,868	0	190	190.00
190.01	19001	UROLOGY	0	0	0	0	42	190.01
190.05	19005	MARKETING	0	26,490	26,490	95	2,538	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	0	364,339	364,339	49	3,959	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	295,597	295,597	0	2,510	190.09
190.11	19011	MHP ADMIN BUILDING	0	92,715	92,715	23	1,314	190.11
190.16	19016	RENOVO	0	322,352	322,352	66	3,917	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	7,417	7,417	1,863	26,276	192.01
194.00	07950	UNAVIE	0	291,193	291,193	141	4,310	194.00
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	9,850,127	9,850,127	38,841	812,790	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	534,520					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,754	50,257				8.00
9.00	00900	HOUSEKEEPING	5,478	0	114,162			9.00
10.00	01000	DIETARY	3,362	0	729	60,675		10.00
11.00	01100	CAFETERIA	11,930	0	2,588	0	214,292	11.00
13.00	01300	NURSING ADMINISTRATION	5,428	0	1,177	0	7,568	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,739	0	1,462	0	0	14.00
15.00	01500	PHARMACY	6,435	0	1,396	0	4,723	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,653	0	1,009	0	10,294	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,596	19,504	11,843	50,839	30,717	30.00
31.00	03100	INTENSIVE CARE UNIT	8,574	0	1,860	9,836	9,532	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,556	4,964	12,703	0	13,399	50.00
53.00	05300	ANESTHESIOLOGY	1,043	0	226	0	3,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,238	8,823	4,173	0	14,653	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	41,503	3,155	9,003	0	7,162	56.01
57.00	05700	CT SCAN	4,349	0	943	0	1,399	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,387	0	952	0	1,740	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	11,980	0	2,599	0	14,686	60.00
65.00	06500	RESPIRATORY THERAPY	9,590	1,254	2,080	0	5,890	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	24,582	1,596	5,332	0	7,831	66.00
69.00	06900	ELECTROCARDIOLOGY	2,540	0	551	0	2,769	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,240	0	3,306	0	8,020	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,005	0	1,953	0	5,014	88.01
88.02	08802	RURAL HEALTH CLINIC III	50,241	0	10,898	0	30,645	88.02
90.00	09000	CLINIC	25,546	0	5,541	0	5,975	90.00
91.00	09100	EMERGENCY	28,555	10,961	6,194	0	14,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	15,313	0	3,322	0	6,196	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	13,306	0	2,886	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444,923	50,257	94,726	60,675	206,713	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,564	0	339	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	95	190.01
190.05	19005	MARKETING	1,666	0	361	0	666	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	22,908	0	4,969	0	739	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	18,586	0	4,032	0	46	190.09
190.11	19011	MHP ADMIN BUILDING	5,830	0	1,265	0	298	190.11
190.16	19016	RENOVO	20,268	0	4,397	0	868	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	466	0	101	0	4,867	192.01
194.00	07950	UNAVIE	18,309	0	3,972	0	0	194.00
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)	534,520	50,257	114,162	60,675	214,292	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	119,573					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	116,205				14.00
15.00	01500	PHARMACY	0	0	209,942			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	107,905		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,247	0	0	3,817	1,138,929	30.00
31.00	03100	INTENSIVE CARE UNIT	7,213	0	0	1,751	196,711	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,139	63,913	0	18,022	1,164,124	50.00
53.00	05300	ANESTHESIOLOGY	2,415	0	0	137	27,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,583	408,911	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	5,419	0	0	6,028	759,629	56.01
57.00	05700	CT SCAN	0	0	0	8,042	91,596	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,624	87,368	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	11,864	285,863	60.00
65.00	06500	RESPIRATORY THERAPY	4,457	0	0	2,500	192,212	65.00
65.01	06501	SLEEP LAB	1,637	0	0	868	7,985	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,979	453,313	66.00
69.00	06900	ELECTROCARDIOLOGY	2,096	0	0	3,725	70,801	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	52,292	0	2,474	69,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	209,942	12,694	222,636	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,069	0	0	1,017	305,635	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,794	0	0	719	180,086	88.01
88.02	08802	RURAL HEALTH CLINIC III	23,191	0	0	3,246	1,014,250	88.02
90.00	09000	CLINIC	4,521	0	0	1,346	467,275	90.00
91.00	09100	EMERGENCY	10,810	0	0	15,441	575,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,688	0	0	1,414	291,415	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	3,723	0	0	614	243,827	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,419	116,205	209,942	107,905	8,255,097	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	26,961	190.00
190.01	19001	UROLOGY	72	0	0	0	209	190.01
190.05	19005	MARKETING	0	0	0	0	31,816	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	559	0	0	0	397,522	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	35	0	0	0	320,806	190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	101,445	190.11
190.16	19016	RENOVO	657	0	0	0	352,525	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,683	0	0	0	44,673	192.01
194.00	07950	UNAVIE	1,148	0	0	0	319,073	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	119,573	116,205	209,942	107,905	9,850,127	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,138,929		30.00
31.00	03100	INTENSIVE CARE UNIT	0	196,711		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,164,124		50.00
53.00	05300	ANESTHESIOLOGY	0	27,040		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	408,911		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	759,629		56.01
57.00	05700	CT SCAN	0	91,596		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	87,368		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	285,863		60.00
65.00	06500	RESPIRATORY THERAPY	0	192,212		65.00
65.01	06501	SLEEP LAB	0	7,985		65.01
66.00	06600	PHYSICAL THERAPY	0	453,313		66.00
69.00	06900	ELECTROCARDIOLOGY	0	70,801		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	69,579		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	222,636		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	305,635		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	180,086		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,014,250		88.02
90.00	09000	CLINIC	0	467,275		90.00
91.00	09100	EMERGENCY	0	575,912		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	291,415		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	243,827		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,255,097		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,961		190.00
190.01	19001	UROLOGY	0	209		190.01
190.05	19005	MARKETING	0	31,816		190.05
190.07	19007	I-74 CAMPUS	0	0		190.07
190.08	19008	RAMPART	0	397,522		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	320,806		190.09
190.11	19011	MHP ADMIN BUILDING	0	101,445		190.11
190.16	19016	RENOVO	0	352,525		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	44,673		192.01
194.00	07950	UNAVIE	0	319,073		194.00
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	9,850,127		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,473					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,173	52,351,864				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,328	9,746,081	-22,965,831	106,471,005		5.00
7.00	00700	OPERATION OF PLANT	15,239	1,229,127	0	3,799,279	256,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,323	100,557	0	474,255	1,323	8.00
9.00	00900	HOUSEKEEPING	2,631	1,454,502	0	2,683,478	2,631	9.00
10.00	01000	DIETARY	1,615	140,571	0	393,429	1,615	10.00
11.00	01100	CAFETERIA	5,730	541,812	0	1,262,197	5,730	11.00
13.00	01300	NURSING ADMINISTRATION	2,607	664,455	0	2,434,132	2,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,237	0	0	107,186	3,237	14.00
15.00	01500	PHARMACY	3,091	1,156,987	0	12,338,077	3,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,235	1,358,816	0	2,218,184	2,235	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,223	5,816,203	0	9,396,921	26,223	30.00
31.00	03100	INTENSIVE CARE UNIT	4,118	1,711,330	0	2,661,443	4,118	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,124	2,415,306	0	6,467,518	28,124	50.00
53.00	05300	ANESTHESIOLOGY	501	688,887	0	383,449	501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,240	2,862,557	0	6,072,354	9,240	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	19,934	1,341,799	0	3,444,437	19,934	56.01
57.00	05700	CT SCAN	2,089	308,339	0	977,520	2,089	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,107	370,559	0	998,436	2,107	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,754	2,118,426	0	6,894,454	5,754	60.00
65.00	06500	RESPIRATORY THERAPY	4,606	1,105,824	0	1,716,350	4,606	65.00
65.01	06501	SLEEP LAB	0	430,362	0	676,036	0	65.01
66.00	06600	PHYSICAL THERAPY	11,807	1,689,756	0	2,590,823	11,807	66.00
69.00	06900	ELECTROCARDIOLOGY	1,220	686,264	0	2,385,869	1,220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	101,941	0	1,796,489	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,320	979,296	0	3,781,837	7,320	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,325	607,554	0	2,087,787	4,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	24,131	3,828,303	0	12,332,440	24,131	88.02
90.00	09000	CLINIC	12,270	1,259,043	0	2,242,432	12,270	90.00
91.00	09100	EMERGENCY	13,715	2,515,629	0	4,409,106	13,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,355	1,237,656	0	2,098,570	7,355	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	6,391	870,601	0	1,444,670	6,391	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	254,439	49,338,543	-22,965,831	100,569,158	213,699	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	751	0	0	24,868	751	190.00
190.01	19001	UROLOGY	0	0	0	5,447	0	190.01
190.05	19005	MARKETING	800	127,547	0	332,489	800	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	11,003	66,122	0	518,548	11,003	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	8,927	0	0	328,783	8,927	190.09
190.11	19011	MHP ADMIN BUILDING	2,800	31,063	0	172,153	2,800	190.11
190.16	19016	RENOVO	9,735	88,650	0	513,039	9,735	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	131	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	224	2,510,562	0	3,441,966	224	192.01
194.00	07950	UNAVIE	8,794	189,377	0	564,554	8,794	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,850,127	10,685,438		22,965,831	4,618,783	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.112676	0.204108		0.215700	17.990609	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		38,841		812,790	534,520	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000742		0.007634	2.082007	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	412,534					8.00
9.00	00900	HOUSEKEEPING	0	252,779				9.00
10.00	01000	DIETARY	0	1,615	9,938			10.00
11.00	01100	CAFETERIA	0	5,730	0	1,161,177		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,607	0	41,008	856,203	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,237	0	0	0	14.00
15.00	01500	PHARMACY	0	3,091	0	25,591	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,235	0	55,778	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	160,104	26,223	8,327	166,447	166,447	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,118	1,611	51,652	51,652	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,746	28,124	0	72,603	72,603	50.00
53.00	05300	ANESTHESIOLOGY	0	501	0	17,294	17,294	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,420	9,240	0	79,401	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	25,896	19,934	0	38,806	38,806	56.01
57.00	05700	CT SCAN	0	2,089	0	7,580	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,107	0	9,431	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	5,754	0	79,578	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,296	4,606	0	31,917	31,917	65.00
65.01	06501	SLEEP LAB	0	0	0	0	11,722	65.01
66.00	06600	PHYSICAL THERAPY	13,099	11,807	0	42,432	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,220	0	15,005	15,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,545	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,320	0	43,456	43,456	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,325	0	27,169	27,169	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	24,131	0	166,056	166,056	88.02
90.00	09000	CLINIC	0	12,270	0	32,375	32,375	90.00
91.00	09100	EMERGENCY	89,973	13,715	0	77,405	77,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	7,355	0	33,572	33,572	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	6,391	0	0	26,655	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,534	209,745	9,938	1,120,101	812,134	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	751	0	0	0	190.00
190.01	19001	UROLOGY	0	0	0	516	516	190.01
190.05	19005	MARKETING	0	800	0	3,610	0	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	0	11,003	0	4,004	4,004	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	8,927	0	251	251	190.09
190.11	19011	MHP ADMIN BUILDING	0	2,800	0	1,616	0	190.11
190.16	19016	RENOVO	0	9,735	0	4,705	4,705	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	224	0	26,374	26,374	192.01
194.00	07950	UNAVIE	0	8,794	0	0	8,219	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	600,354	3,309,637	528,492	1,712,562	3,100,690	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.455284	13.093006	53.178909	1.474850	3.621443	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,257	114,162	60,675	214,292	119,573	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.121825	0.451628	6.105353	0.184547	0.139655	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	409,840,924		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	14,514,070		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,656,379		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	55	0	68,083,492		50.00
53.00	05300	ANESTHESIOLOGY	0	0	520,745		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	28,834,268		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	05601	ONCOLOGY	0	0	22,918,754		56.01
57.00	05700	CT SCAN	0	0	30,578,599		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	9,976,474		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	45,110,564		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	9,505,989		65.00
65.01	06501	SLEEP LAB	0	0	3,298,832		65.01
66.00	06600	PHYSICAL THERAPY	0	0	7,525,737		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14,165,366		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45	0	9,406,258		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	48,265,732		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	3,866,121		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,734,310		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	12,341,608		88.02
90.00	09000	CLINIC	0	0	5,118,059		90.00
91.00	09100	EMERGENCY	0	0	58,709,255		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	5,377,191		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	2,333,121		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	409,840,924		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	UROLOGY	0	0	0		190.01
190.05	19005	MARKETING	0	0	0		190.05
190.07	19007	I-74 CAMPUS	0	0	0		190.07
190.08	19008	RAMPART	0	0	0		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0		190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0		190.11
190.16	19016	RENOVO	0	0	0		190.16
190.17	19017	IMA	0	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0	0		190.18
190.19	19019	MHCD	0	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	HOSPITALIST	0	0	0		192.01
194.00	07950	UNAVIE	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	230,924	15,133,256	2,848,382		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,309.240000	151,332.560000	0.006950		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	116,205	209,942	107,905		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	1,162.050000	2,099.420000	0.000263		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,863,893		13,863,893	0	13,863,893	30.00
31.00	03100	INTENSIVE CARE UNIT	3,758,685		3,758,685	0	3,758,685	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,766,244		9,766,244	0	9,766,244	50.00
53.00	05300	ANESTHESIOLOGY	573,486		573,486	317,624	891,110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,092,268		8,092,268	0	8,092,268	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	5,201,761		5,201,761	5,392	5,207,153	56.01
57.00	05700	CT SCAN	1,477,004		1,477,004	0	1,477,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,362,537		1,362,537	0	1,362,537	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	8,991,327		8,991,327	114,320	9,105,647	60.00
65.00	06500	RESPIRATORY THERAPY	2,473,448	0	2,473,448	0	2,473,448	65.00
65.01	06501	SLEEP LAB	887,235	0	887,235	0	887,235	65.01
66.00	06600	PHYSICAL THERAPY	3,650,616	0	3,650,616	0	3,650,616	66.00
69.00	06900	ELECTROCARDIOLOGY	3,113,342		3,113,342	0	3,113,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,361,459		2,361,459	0	2,361,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,468,703		15,468,703	0	15,468,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,073,445		5,073,445	0	5,073,445	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,830,023		2,830,023	0	2,830,023	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,674,669		16,674,669	0	16,674,669	88.02
90.00	09000	CLINIC	3,308,084		3,308,084	23,993	3,332,077	90.00
91.00	09100	EMERGENCY	6,719,906		6,719,906	19,127	6,739,033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,123,064		1,123,064		1,123,064	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,988,316		2,988,316	0	2,988,316	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,067,685		2,067,685		2,067,685	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,827,200	0	121,827,200	480,456	122,307,656	200.00
201.00		Less Observation Beds	1,123,064		1,123,064		1,123,064	201.00
202.00		Total (see instructions)	120,704,136	0	120,704,136	480,456	121,184,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm

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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	13,368,717		13,368,717			30.00
31.00	03100	INTENSIVE CARE UNIT	6,656,379		6,656,379			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,783,177	56,300,315	68,083,492	0.143445	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	520,745	520,745	1.101280	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,809,569	26,024,699	28,834,268	0.280648	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	172,613	22,746,141	22,918,754	0.226965	0.000000	56.01
57.00	05700	CT SCAN	5,731,237	24,847,362	30,578,599	0.048302	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	954,261	9,022,213	9,976,474	0.136575	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	8,116,336	36,994,228	45,110,564	0.199318	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,473,129	1,032,860	9,505,989	0.260199	0.000000	65.00
65.01	06501	SLEEP LAB	5,247	3,293,585	3,298,832	0.268954	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,223,530	6,302,207	7,525,737	0.485084	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,272,961	11,892,405	14,165,366	0.219785	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,978,692	5,427,566	9,406,258	0.251052	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,112,518	35,153,214	48,265,732	0.320490	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,866,121	3,866,121			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,734,310	2,734,310			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	12,341,608	12,341,608			88.02
90.00	09000	CLINIC	28,831	5,089,228	5,118,059	0.646355	0.000000	90.00
91.00	09100	EMERGENCY	11,072,090	47,637,165	58,709,255	0.114461	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,644	1,131,709	1,145,353	0.980540	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,582,019	3,795,172	5,377,191	0.555739	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,333,121	2,333,121			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	91,354,950	318,485,974	409,840,924			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	91,354,950	318,485,974	409,840,924			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm

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		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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.143445		50.00
53.00	05300	ANESTHESIOLOGY	1.711221		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.280648		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ONCOLOGY	0.227201		56.01
57.00	05700	CT SCAN	0.048302		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136575		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.201852		60.00
65.00	06500	RESPIRATORY THERAPY	0.260199		65.00
65.01	06501	SLEEP LAB	0.268954		65.01
66.00	06600	PHYSICAL THERAPY	0.485084		66.00
69.00	06900	ELECTROCARDIOLOGY	0.219785		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.251052		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320490		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.651043		90.00
91.00	09100	EMERGENCY	0.114787		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980540		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.555739		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,863,893		13,863,893	0	13,863,893	30.00
31.00	03100	INTENSIVE CARE UNIT	3,758,685		3,758,685	0	3,758,685	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,766,244		9,766,244	0	9,766,244	50.00
53.00	05300	ANESTHESIOLOGY	573,486		573,486	317,624	891,110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,092,268		8,092,268	0	8,092,268	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	5,201,761		5,201,761	5,392	5,207,153	56.01
57.00	05700	CT SCAN	1,477,004		1,477,004	0	1,477,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,362,537		1,362,537	0	1,362,537	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	8,991,327		8,991,327	114,320	9,105,647	60.00
65.00	06500	RESPIRATORY THERAPY	2,473,448	0	2,473,448	0	2,473,448	65.00
65.01	06501	SLEEP LAB	887,235	0	887,235	0	887,235	65.01
66.00	06600	PHYSICAL THERAPY	3,650,616	0	3,650,616	0	3,650,616	66.00
69.00	06900	ELECTROCARDIOLOGY	3,113,342		3,113,342	0	3,113,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,361,459		2,361,459	0	2,361,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,468,703		15,468,703	0	15,468,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,073,445		5,073,445	0	5,073,445	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,830,023		2,830,023	0	2,830,023	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,674,669		16,674,669	0	16,674,669	88.02
90.00	09000	CLINIC	3,308,084		3,308,084	23,993	3,332,077	90.00
91.00	09100	EMERGENCY	6,719,906		6,719,906	19,127	6,739,033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,123,064		1,123,064		1,123,064	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,988,316		2,988,316	0	2,988,316	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,067,685		2,067,685		2,067,685	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,827,200	0	121,827,200	480,456	122,307,656	200.00
201.00		Less Observation Beds	1,123,064		1,123,064		1,123,064	201.00
202.00		Total (see instructions)	120,704,136	0	120,704,136	480,456	121,184,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,368,717		13,368,717			30.00
31.00	03100	INTENSIVE CARE UNIT	6,656,379		6,656,379			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,783,177	56,300,315	68,083,492	0.143445	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	520,745	520,745	1.101280	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,809,569	26,024,699	28,834,268	0.280648	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	172,613	22,746,141	22,918,754	0.226965	0.000000	56.01
57.00	05700	CT SCAN	5,731,237	24,847,362	30,578,599	0.048302	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	954,261	9,022,213	9,976,474	0.136575	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	8,116,336	36,994,228	45,110,564	0.199318	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,473,129	1,032,860	9,505,989	0.260199	0.000000	65.00
65.01	06501	SLEEP LAB	5,247	3,293,585	3,298,832	0.268954	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,223,530	6,302,207	7,525,737	0.485084	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,272,961	11,892,405	14,165,366	0.219785	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,978,692	5,427,566	9,406,258	0.251052	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,112,518	35,153,214	48,265,732	0.320490	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,866,121	3,866,121	1.312283	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,734,310	2,734,310	1.035004	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	12,341,608	12,341,608	1.351094	0.000000	88.02
90.00	09000	CLINIC	28,831	5,089,228	5,118,059	0.646355	0.000000	90.00
91.00	09100	EMERGENCY	11,072,090	47,637,165	58,709,255	0.114461	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,644	1,131,709	1,145,353	0.980540	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,582,019	3,795,172	5,377,191	0.555739	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,333,121	2,333,121			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	91,354,950	318,485,974	409,840,924			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	91,354,950	318,485,974	409,840,924			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ONCOLOGY	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,138,929	0	1,138,929	9,061	125.70	30.00
31.00	INTENSIVE CARE UNIT	196,711		196,711	1,611	122.10	31.00
200.00	Total (lines 30 through 199)	1,335,640		1,335,640	10,672		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,102	389,921	30.00
31.00	INTENSIVE CARE UNIT	567	69,231	31.00
200.00	Total (lines 30 through 199)	3,669	459,152	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,164,124	68,083,492	0.017098	4,009,747	68,559	50.00
53.00	05300	ANESTHESIOLOGY	27,040	520,745	0.051926	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	408,911	28,834,268	0.014181	1,239,772	17,581	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	759,629	22,918,754	0.033144	15,787	523	56.01
57.00	05700	CT SCAN	91,596	30,578,599	0.002995	2,371,401	7,102	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	87,368	9,976,474	0.008757	423,359	3,707	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	285,863	45,110,564	0.006337	3,296,826	20,892	60.00
65.00	06500	RESPIRATORY THERAPY	192,212	9,505,989	0.020220	3,156,435	63,823	65.00
65.01	06501	SLEEP LAB	7,985	3,298,832	0.002421	0	0	65.01
66.00	06600	PHYSICAL THERAPY	453,313	7,525,737	0.060235	639,075	38,495	66.00
69.00	06900	ELECTROCARDIOLOGY	70,801	14,165,366	0.004998	994,999	4,973	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	69,579	9,406,258	0.007397	2,210,715	16,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,636	48,265,732	0.004613	4,744,898	21,888	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	305,635	3,866,121	0.079055	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	180,086	2,734,310	0.065862	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,014,250	12,341,608	0.082181	0	0	88.02
90.00	09000	CLINIC	467,275	5,118,059	0.091299	13,515	1,234	90.00
91.00	09100	EMERGENCY	575,912	58,709,255	0.009810	4,473,784	43,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,261	1,145,353	0.080552	7,335	591	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	291,415	5,377,191	0.054195	829,383	44,948	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,767,891	387,482,707		28,427,031	354,557	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	9,061	0.00	3,102	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,611	0.00	567	31.00
200.00		Total (lines 30 through 199)		0	10,672		3,669	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
200.00		Total (lines 30 through 199)	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 2:11 pm

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		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 2:11 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	68,083,492	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	520,745	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,834,268	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	0	0	0	22,918,754	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	30,578,599	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,976,474	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	45,110,564	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,505,989	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,298,832	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	7,525,737	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,165,366	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,406,258	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	48,265,732	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,866,121	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,734,310	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	12,341,608	0.000000	88.02
90.00	09000	CLINIC	0	0	0	5,118,059	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	58,709,255	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,145,353	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	5,377,191	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	387,482,707		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	4,009,747	0	10,339,195	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	517,154	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,239,772	0	5,117,096	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.000000	15,787	0	7,551,297	0	56.01
57.00	05700	CT SCAN	0.000000	2,371,401	0	5,761,622	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	423,359	0	2,336,960	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	3,296,826	0	3,102,287	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,156,435	0	910,109	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	639,075	0	13,364	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	994,999	0	3,322,806	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	2,210,715	0	1,247,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,744,898	0	11,442,436	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	13,515	0	2,092,032	0	90.00
91.00	09100	EMERGENCY	0.000000	4,473,784	0	7,249,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	7,335	0	492,287	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	829,383	0	771,775	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		28,427,031	0	62,267,467	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.143445	10,339,195	0	0	1,483,106	50.00
53.00	05300	ANESTHESIOLOGY	1.101280	517,154	0	0	569,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.280648	5,117,096	0	0	1,436,103	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.226965	7,551,297	0	0	1,713,880	56.01
57.00	05700	CT SCAN	0.048302	5,761,622	0	0	278,298	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136575	2,336,960	0	0	319,170	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.199318	3,102,287	0	0	618,342	60.00
65.00	06500	RESPIRATORY THERAPY	0.260199	910,109	0	0	236,809	65.00
65.01	06501	SLEEP LAB	0.268954	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.485084	13,364	0	0	6,483	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219785	3,322,806	0	0	730,303	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.251052	1,247,388	0	0	313,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320490	11,442,436	0	13,341	3,667,186	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.646355	2,092,032	0	0	1,352,195	90.00
91.00	09100	EMERGENCY	0.114461	7,249,659	0	0	829,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980540	492,287	0	0	482,707	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.555739	771,775	0	0	428,905	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		62,267,467	0	13,341	14,465,980	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		62,267,467	0	13,341	14,465,980	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 2:11 pm

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		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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	0	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,276	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	4,276	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	4,276	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,061	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,061	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)	8,327	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,102	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)	13,863,893	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)	13,863,893	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)	13,863,893	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)	1,530.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,746,246	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)	4,746,246	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,758,685	1,611	2,333.14	567	1,322,890	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)	6,180,670	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,249,806	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)	459,152	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	354,557	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	813,709	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,436,097	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)	734	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,530.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,123,064	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,138,929	13,863,893	0.082151	1,123,064	92,261	90.00
91.00	Nursing School cost	0	13,863,893	0.000000	1,123,064	0	91.00
92.00	Allied health cost	0	13,863,893	0.000000	1,123,064	0	92.00
93.00	All other Medical Education	0	13,863,893	0.000000	1,123,064	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,061	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,061	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)	8,327	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)	326	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)	13,863,893	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)	13,863,893	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)	13,863,893	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)	1,530.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	498,800	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)	498,800	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,758,685	1,611	2,333.14	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)	430,355	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	929,155	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)	734	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,530.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,123,064	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,138,929	13,863,893	0.082151	1,123,064	92,261	90.00
91.00	Nursing School cost	0	13,863,893	0.000000	1,123,064	0	91.00
92.00	Allied health cost	0	13,863,893	0.000000	1,123,064	0	92.00
93.00	All other Medical Education	0	13,863,893	0.000000	1,123,064	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,019,371		30.00
31.00	03100	INTENSIVE CARE UNIT		1,852,600		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.143445	4,009,747	575,178	50.00
53.00	05300	ANESTHESIOLOGY	1.711221	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.280648	1,239,772	347,940	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.227201	15,787	3,587	56.01
57.00	05700	CT SCAN	0.048302	2,371,401	114,543	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136575	423,359	57,820	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.201852	3,296,826	665,471	60.00
65.00	06500	RESPIRATORY THERAPY	0.260199	3,156,435	821,301	65.00
65.01	06501	SLEEP LAB	0.268954	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.485084	639,075	310,005	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219785	994,999	218,686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.251052	2,210,715	555,004	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320490	4,744,898	1,520,692	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.651043	13,515	8,799	90.00
91.00	09100	EMERGENCY	0.114787	4,473,784	513,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980540	7,335	7,192	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.555739	829,383	460,920	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,427,031	6,180,670	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)		28,427,031		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		618,895		30.00
31.00	03100	INTENSIVE CARE UNIT		223,661		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.143445	482,622	69,230	50.00
53.00	05300	ANESTHESIOLOGY	1.101280	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.280648	81,160	22,777	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.226965	409	93	56.01
57.00	05700	CT SCAN	0.048302	165,431	7,991	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136575	31,101	4,248	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.199318	306,198	61,031	60.00
65.00	06500	RESPIRATORY THERAPY	0.260199	257,701	67,054	65.00
65.01	06501	SLEEP LAB	0.268954	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.485084	19,062	9,247	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219785	63,494	13,955	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.251052	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320490	409,312	131,180	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.312283	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.035004	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.351094	0	0	88.02
90.00	09000	CLINIC	0.646355	0	0	90.00
91.00	09100	EMERGENCY	0.114461	380,473	43,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980540	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.555739	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,196,963	430,355	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,196,963		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 2:11 pm
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,958,381	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,760,658	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)	82,920	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	29,025	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)	43.99	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.04	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.57	31.00
32.00	Sum of lines 30 and 31	24.61	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.52	33.00
34.00	Disproportionate share adjustment (see instructions)	207,514	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000158965	0.000140021	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,327,454	1,160,779	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	993,777	292,580	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,286,357		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)	10,324,855		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)	10,324,855	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	672,693	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,997,548	59.00
60.00	Primary payer payments	7,531	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,990,017	61.00
62.00	Deductibles billed to program beneficiaries	1,072,544	62.00
63.00	Coinsurance billed to program beneficiaries	5,984	63.00
64.00	Allowable bad debts (see instructions)	120,117	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	78,076	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,307	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,989,565	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)	44,314	70.93
70.94	HRR adjustment amount (see instructions)	-30,822	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A | Date/Time Prepared: 8/2/2021 2:11 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	609,148	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	233,273	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,845,478	71.00
71.01	Sequestration adjustment (see instructions)		71,580	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		10,499,439	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)		274,459	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		233,258	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/2/2021 2:11 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,958,381	0	5,958,381		5,958,381	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,760,658	0		2,760,658	2,760,658	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	82,920	0	82,920		82,920	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29,025	0		29,025	29,025	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	0.0952	0.0952	0.0952	0.0952		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	207,514	0	141,810	65,704	207,514	11.00
11.01	Uncompensated care payments	36.00	1,286,357	0	993,777	292,580	1,286,357	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	10,324,855	0	7,176,888	3,147,967	10,324,855	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	10,324,855	0	7,176,888	3,147,967	10,324,855	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/2/2021 2:11 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	672,693	0	473,704	198,989	672,693	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	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	7,650,592	3,346,956	10,997,548	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	665,282	0	466,329	198,953	665,282	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	7,411	0	7,375	36	7,411	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	672,693	0	473,704	198,989	672,693	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				0.079621	0.069697		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			609,148		609,148	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				233,273	233,273	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 2:11 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,958,381	5,958,381		5,958,381	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,760,658		2,760,658	2,760,658	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	82,920	82,920		82,920	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29,025		29,025	29,025	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	0.0952	0.0952	0.0952		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	207,514	141,810	65,704	207,514	11.00
11.01	Uncompensated care payments	36.00	1,286,357	993,777	292,580	1,286,357	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	10,324,855	7,176,888	3,147,967	10,324,855	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	10,324,855	7,176,888	3,147,967	10,324,855	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	672,693	473,704	198,989	672,693	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,650,592	3,346,956	10,997,548	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	665,282	466,329	198,953	665,282	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	7,411	7,375	36	7,411	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	672,693	473,704	198,989	672,693	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	609,148	609,148		609,148	28.00
29.00	Low volume adjustment on or after October 1	70.97	233,273		233,273	233,273	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	44,314	28,094	16,220	44,314	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	-30,822	-25,025	-5,797	-30,822	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,276	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	14,465,980	2.00
3.00	OPPS payments	9,858,514	3.00
4.00	Outlier payment (see instructions)	65,124	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,276	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,341	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)	13,341	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)	13,341	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,065	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)	4,276	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)	9,923,638	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)	1,826,530	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)	8,101,384	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)	8,101,384	30.00
31.00	Primary payer payments	1,450	31.00
32.00	Subtotal (line 30 minus line 31)	8,099,934	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)	308,153	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	200,299	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	167,577	36.00
37.00	Subtotal (see instructions)	8,300,233	37.00
38.00	MSP-LCC reconciliation amount from PS&R	198	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)	8,300,035	40.00
40.01	Sequestration adjustment (see instructions)	54,780	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	8,252,058	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)	-6,803	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,460,005		8,046,572	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	39,434	12/31/2020	205,486	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)		39,434		205,486	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)		10,499,439		8,252,058	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		274,459		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		6,803	6.02
7.00	Total Medicare program liability (see instructions)		10,773,898		8,245,255	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: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 2:11 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	929,155		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)	929,155	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)	929,155	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	842,556		8.00
9.00	Ancillary service charges	2,196,963	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	3,039,519	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	3,039,519	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,110,364	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)	929,155	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)	929,155	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)	929,155	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)	929,155	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	929,155	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)	929,155	0	40.00
41.00	Interim payments	1,149,907	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-220,752	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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 8/2/2021 2:11 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	16,304,627	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	42,176,281	0	0	0	4.00
5.00	Other receivable	10,634,242	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-29,072,978	0	0	0	6.00
7.00	Inventory	5,446,190	0	0	0	7.00
8.00	Prepaid expenses	3,392,559	0	0	0	8.00
9.00	Other current assets	4,221	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)	48,885,142	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,900,662	0	0	0	12.00
13.00	Land improvements	12,298,052	0	0	0	13.00
14.00	Accumulated depreciation	-4,641,265	0	0	0	14.00
15.00	Buildings	128,903,484	0	0	0	15.00
16.00	Accumulated depreciation	-24,928,346	0	0	0	16.00
17.00	Leasehold improvements	268,012	0	0	0	17.00
18.00	Accumulated depreciation	-247,057	0	0	0	18.00
19.00	Fixed equipment	4,650,236	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	62,862,730	0	0	0	23.00
24.00	Accumulated depreciation	-38,644,275	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)	143,422,233	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	848,792	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	281,994,744	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	282,843,536	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	475,150,911	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,779,366	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,551,970	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	45,636,916	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	62,968,252	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	99,039,051	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	99,039,051	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	162,007,303	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	313,143,608				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)	313,143,608	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	475,150,911	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 8/2/2021 2:11 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		319,409,410		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,265,802				2.00
3.00	Total (sum of line 1 and line 2)		313,143,608		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)		313,143,608		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ADJUSTMENT	0		0		0	13.00
14.00	ROUNDING	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)		313,143,608		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	ADJUSTMENT		0		13.00
14.00	ROUNDING		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: 15-0097 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/2/2021 2:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,177,715		14,177,715	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,177,715		14,177,715	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,992,734		6,992,734	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)	6,992,734		6,992,734	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,170,449		21,170,449	17.00
18.00	Ancillary services	58,633,270	242,291,451	300,924,721	18.00
19.00	Outpatient services	12,682,940	56,521,565	69,204,505	19.00
20.00	RURAL HEALTH CLINIC	0	3,866,121	3,866,121	20.00
20.01	RURAL HEALTH CLINIC II	0	2,734,310	2,734,310	20.01
20.02	RURAL HEALTH CLINIC III	0	12,341,608	12,341,608	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,333,121	2,333,121	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN / OTHER	0	4,306,041	4,306,041	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	92,486,659	324,394,217	416,880,876	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		145,961,860		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)		145,961,860		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 8/2/2021 2:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	416,880,876	1.00
2.00	Less contractual allowances and discounts on patients' accounts	292,732,279	2.00
3.00	Net patient revenues (line 1 minus line 2)	124,148,597	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	145,961,860	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,813,263	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	4,309,802	24.00
24.01	OTHER REVENUE	14,711,135	24.01
24.50	COVID-19 PHE Funding	3,102,081	24.50
25.00	Total other income (sum of lines 6-24)	22,123,018	25.00
26.00	Total (line 5 plus line 25)	309,755	26.00
27.00	TRANSFERS	6,575,557	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	6,575,557	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,265,802	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0097 HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H Date/Time Prepared: 8/2/2021 2:11 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		3,198	3,198	1.00
2.00	Capital Related - Movable Equipment			0		30,753	30,753	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	285	285	3.00
4.00	Transportation	0	0	44,401	0	0	44,401	4.00
5.00	Administrative and General	870,601	65,757	0	0	3,948	940,306	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	38,053	38,053	12.00
13.00	Drugs	0	0	0	0	190	190	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	870,601	65,757	44,401	0	76,427	1,057,186	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	3,198	0	3,198			1.00
2.00	Capital Related - Movable Equipment	0	30,753	0	30,753			2.00
3.00	Plant Operation & Maintenance	0	285	0	285			3.00
4.00	Transportation	0	44,401	0	44,401			4.00
5.00	Administrative and General	-674,648	265,658	-1,836	263,822			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	346,114	346,114	0	346,114			6.00
7.00	Physical Therapy	170,486	170,486	0	170,486			7.00
8.00	Occupational Therapy	109,865	109,865	0	109,865			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	836	836	0	836			10.00
11.00	Home Health Aide	47,347	47,347	0	47,347			11.00
12.00	Supplies (see instructions)	0	38,053	0	38,053			12.00
13.00	Drugs	0	190	0	190			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,057,186	-1,836	1,055,350			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-1 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,198	3,198				0	1.00
2.00	Capital Related - Movable Equipment	30,753		30,753			0	2.00
3.00	Plant Operation & Maintenance	285	0	0	285		0	3.00
4.00	Transportation	44,401	0	0	0	44,401		4.00
5.00	Administrative and General	263,822	3,198	30,753	285	44,401	342,459	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	346,114	0	0	0	0	346,114	6.00
7.00	Physical Therapy	170,486	0	0	0	0	170,486	7.00
8.00	Occupational Therapy	109,865	0	0	0	0	109,865	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	836	0	0	0	0	836	10.00
11.00	Home Health Aide	47,347	0	0	0	0	47,347	11.00
12.00	Supplies (see instructions)	38,053	0	0	0	0	38,053	12.00
13.00	Drugs	190	0	0	0		190	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,055,350	3,198	30,753	285	44,401	1,055,350	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	342,459		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	166,266	512,380	6.00
7.00	Physical Therapy	81,898	252,384	7.00
8.00	Occupational Therapy	52,777	162,642	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	402	1,238	10.00
11.00	Home Health Aide	22,745	70,092	11.00
12.00	Supplies (see instructions)	18,280	56,333	12.00
13.00	Drugs	91	281	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,055,350	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-1 Part II Date/Time Prepared: 8/2/2021 2:11 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	100				0		1.00
2.00	Capital Related - Movable Equipment		100			0		2.00
3.00	Plant Operation & Maintenance	0	0	100		0		3.00
4.00	Transportation (see instructions)	0	0	0	100			4.00
5.00	Administrative and General	100	100	100	100	-342,459	712,891	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	346,114	6.00
7.00	Physical Therapy	0	0	0	0	0	170,486	7.00
8.00	Occupational Therapy	0	0	0	0	0	109,865	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	836	10.00
11.00	Home Health Aide	0	0	0	0	0	47,347	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	38,053	12.00
13.00	Drugs	0	0	0		0	190	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	100	100	100	100	-342,459	712,891	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	3,198	30,753	285	44,401		342,459	25.00
26.00	Unit Cost Multiplier	31.980000	307.530000	2.850000	444.010000		0.480381	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0097 HHA CCN: 15-7418

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

Worksheet H-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	211,623	177,697	389,320	83,976	114,978	1.00
2.00	Skilled Nursing Care	512,380	0	0	512,380	110,520	0	2.00
3.00	Physical Therapy	252,384	0	0	252,384	54,439	0	3.00
4.00	Occupational Therapy	162,642	0	0	162,642	35,082	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,238	0	0	1,238	267	0	6.00
7.00	Home Health Aide	70,092	0	0	70,092	15,119	0	7.00
8.00	Supplies (see instructions)	56,333	0	0	56,333	12,151	0	8.00
9.00	Drugs	281	0	0	281	61	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,055,350	211,623	177,697	1,444,670	311,615	114,978	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	83,677	0	0	96,530	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	83,677	0	0	96,530	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0097 HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm

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	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	16,215	784,696	0	784,696		1.00
2.00	Skilled Nursing Care	0	0	622,900	0	622,900	380,976	2.00
3.00	Physical Therapy	0	0	306,823	0	306,823	187,658	3.00
4.00	Occupational Therapy	0	0	197,724	0	197,724	120,931	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	1,505	0	1,505	920	6.00
7.00	Home Health Aide	0	0	85,211	0	85,211	52,116	7.00
8.00	Supplies (see instructions)	0	0	68,484	0	68,484	41,886	8.00
9.00	Drugs	0	0	342	0	342	209	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	16,215	2,067,685	0	2,067,685	784,696	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.611616	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	1,003,876	2.00
3.00	Physical Therapy	494,481	3.00
4.00	Occupational Therapy	318,655	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	2,425	6.00
7.00	Home Health Aide	137,327	7.00
8.00	Supplies (see instructions)	110,370	8.00
9.00	Drugs	551	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,067,685	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part II | Date/Time Prepared: 8/2/2021 2:11 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	6,391	870,601	0	389,320	6,391	0	1.00
2.00	Skilled Nursing Care	0	0	0	512,380	0	0	2.00
3.00	Physical Therapy	0	0	0	252,384	0	0	3.00
4.00	Occupational Therapy	0	0	0	162,642	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	1,238	0	0	6.00
7.00	Home Health Aide	0	0	0	70,092	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	56,333	0	0	8.00
9.00	Drugs	0	0	0	281	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	6,391	870,601		1,444,670	6,391	0	20.00
21.00	Total cost to be allocated	211,623	177,697		311,615	114,978	0	21.00
22.00	Unit cost multiplier	33.112658	0.204108		0.215700	17.990612	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	6,391	0	0	26,655	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	6,391	0	0	26,655	0	0	20.00
21.00	Total cost to be allocated	83,677	0	0	96,530	0	0	21.00
22.00	Unit cost multiplier	13.092943	0.000000	0.000000	3.621459	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0097
HHA CCN: 15-7418

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

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	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)					
		16.00					
1.00	Administrative and General	2,333,121					1.00
2.00	Skilled Nursing Care	0					2.00
3.00	Physical Therapy	0					3.00
4.00	Occupational Therapy	0					4.00
5.00	Speech Pathology	0					5.00
6.00	Medical Social Services	0					6.00
7.00	Home Health Aide	0					7.00
8.00	Supplies (see instructions)	0					8.00
9.00	Drugs	0					9.00
10.00	DME	0					10.00
11.00	Home Dialysis Aide Services	0					11.00
12.00	Respiratory Therapy	0					12.00
13.00	Private Duty Nursing	0					13.00
14.00	Clinic	0					14.00
15.00	Health Promotion Activities	0					15.00
16.00	Day Care Program	0					16.00
17.00	Home Delivered Meals Program	0					17.00
18.00	Homemaker Service	0					18.00
19.00	All Others (specify)	0					19.00
19.50	Telemedicine	0					19.50
20.00	Total (sum of lines 1-19)	2,333,121					20.00
21.00	Total cost to be allocated	16,215					21.00
22.00	Unit cost multiplier	0.006950					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,003,876		1,003,876	4,044	248.24	1.00
2.00	Physical Therapy	3.00	494,481	0	494,481	2,796	176.85	2.00
3.00	Occupational Therapy	4.00	318,655	0	318,655	1,273	250.32	3.00
4.00	Speech Pathology	5.00	0	0	0	24	0.00	4.00
5.00	Medical Social Services	6.00	2,425		2,425	44	55.11	5.00
6.00	Home Health Aide	7.00	137,327		137,327	614	223.66	6.00
7.00	Total (sum of lines 1-6)		1,956,764	0	1,956,764	8,795		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		26900	0	2,255			8.00
8.01	Skilled Nursing Care		99915	0	101			8.01
9.00	Physical Therapy		26900	0	1,501			9.00
9.01	Physical Therapy		99915	0	154			9.01
10.00	Occupational Therapy		26900	0	690			10.00
10.01	Occupational Therapy		99915	0	43			10.01
11.00	Speech Pathology		26900	0	15			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		26900	0	25			12.00
12.01	Medical Social Services		99915	0	2			12.01
13.00	Home Health Aide		26900	0	430			13.00
13.01	Home Health Aide		99915	0	26			13.01
14.00	Total (sum of lines 8-13)			0	5,242			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	110,370	0	110,370	340,546	0.324097	15.00
16.00	Cost of Drugs	9.00	551	0	551	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,356		0	584,853		1.00
2.00	Physical Therapy	0	1,655		0	292,687		2.00
3.00	Occupational Therapy	0	733		0	183,485		3.00
4.00	Speech Pathology	0	15		0	0		4.00
5.00	Medical Social Services	0	27		0	1,488		5.00
6.00	Home Health Aide	0	456		0	101,989		6.00
7.00	Total (sum of lines 1-6)	0	5,242		0	1,164,502		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part I | Date/Time Prepared: 8/2/2021 2:11 pm

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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	227,793	0	0	73,827	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	584,853	1.00
2.00	Physical Therapy	292,687	2.00
3.00	Occupational Therapy	183,485	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	1,488	5.00
6.00	Home Health Aide	101,989	6.00
7.00	Total (sum of lines 1-6)	1,164,502	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0097
HHA CCN: 15-7418

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

Worksheet H-3
Part II
Date/Time Prepared:
8/2/2021 2:11 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.485084	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.000000	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.320490	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 8/2/2021 2:11 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	615,237	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	152,543	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,686	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	20,810	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	58,963	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,234	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	858,473	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	858,473	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	858,473	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	858,473	29.00
30.00	OTHER ADJ	0	1,010	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	859,483	31.00
31.01	Sequestration adjustment (see instructions)	0	8,865	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	850,618	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-0097 HHA CCN: 15-7418 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-5 Date/Time Prepared: 8/2/2021 2:11 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		850,618	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		850,618	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		850,618	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0097	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		665,282	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,411	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)		27.39	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)		672,693	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: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC I

		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	0	806,577	806,577	57,416	863,993	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	102,231	0	102,231	0	102,231	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	27,837	0	27,837	0	27,837	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	609,255	0	609,255	0	609,255	9.00
10.00	Subtotal (sum of lines 1 through 9)	739,323	806,577	1,545,900	57,416	1,603,316	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	437,230	437,230	0	437,230	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	437,230	437,230	0	437,230	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	739,323	1,243,807	1,983,130	57,416	2,040,546	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	84,973	84,973	0	84,973	29.00
30.00	Administrative Costs	182,558	88,494	271,052	0	271,052	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	182,558	173,467	356,025	0	356,025	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	921,881	1,417,274	2,339,155	57,416	2,396,571	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	863,993		1.00
2.00	Physician Assistant	209,338	209,338		2.00
3.00	Nurse Practitioner	411,451	513,682		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	27,837		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	609,255		9.00
10.00	Subtotal (sum of lines 1 through 9)	620,789	2,224,105		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	437,230		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	437,230		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	620,789	2,661,335		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	84,973		29.00
30.00	Administrative Costs	322,210	593,262		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	322,210	678,235		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	942,999	3,339,570		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC II

		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	0	728,534	728,534	0	728,534	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	104,277	0	104,277	0	104,277	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	26,567	0	26,567	0	26,567	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	325,841	0	325,841	0	325,841	9.00
10.00	Subtotal (sum of lines 1 through 9)	456,685	728,534	1,185,219	0	1,185,219	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	333,903	333,903	0	333,903	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	333,903	333,903	0	333,903	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	456,685	1,062,437	1,519,122	0	1,519,122	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	24,539	24,539	0	24,539	29.00
30.00	Administrative Costs	150,869	61,414	212,283	0	212,283	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	150,869	85,953	236,822	0	236,822	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	607,554	1,148,390	1,755,944	0	1,755,944	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-84,938	643,596		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	104,277		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	26,567		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	325,841		9.00
10.00	Subtotal (sum of lines 1 through 9)	-84,938	1,100,281		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	333,903		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	333,903		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-84,938	1,434,184		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	24,539		29.00
30.00	Administrative Costs	149,562	361,845		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	149,562	386,384		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	64,624	1,820,568		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC III

		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	0	2,953,448	2,953,448	0	2,953,448	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	126,541	240	126,781	0	126,781	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	3,048	3,048	0	3,048	6.00
7.00	Clinical Social Worker	49,509	0	49,509	0	49,509	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	2,255,856	0	2,255,856	0	2,255,856	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,431,906	2,956,736	5,388,642	0	5,388,642	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	186,801	704,917	891,718	0	891,718	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)	186,801	704,917	891,718	0	891,718	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,618,707	3,661,653	6,280,360	0	6,280,360	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	597,343	597,343	0	597,343	29.00
30.00	Administrative Costs	1,209,596	461,075	1,670,671	0	1,670,671	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,209,596	1,058,418	2,268,014	0	2,268,014	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,828,303	4,720,071	8,548,374	0	8,548,374	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-58,227	2,895,221		1.00
2.00	Physician Assistant	153,889	153,889		2.00
3.00	Nurse Practitioner	1,147,576	1,274,357		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	3,048		6.00
7.00	Clinical Social Worker	0	49,509		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	2,255,856		9.00
10.00	Subtotal (sum of lines 1 through 9)	1,243,238	6,631,880		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	891,718		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	891,718		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,243,238	7,523,598		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	597,343		29.00
30.00	Administrative Costs	960,399	2,631,070		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	960,399	3,228,413		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,203,637	10,752,011		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.65	8,380	1	4		1.00
2.00	Physician Assistant	0.70	1,764	1	1		2.00
3.00	Nurse Practitioner	3.60	7,092	1	4		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.95	17,236		9	17,236	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	0.37	515			515	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)	8.32	17,751			17,751	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)					2,661,335	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,661,335	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					678,235	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,733,875	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,412,110	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,412,110	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,412,110	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,073,445	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097 Component CCN: 15-8531

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

Worksheet M-2 Date/Time Prepared: 8/2/2021 2:11 pm

RHC II

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.70	4,406	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.88	1,960	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.58	6,366		3	6,366	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)	2.58	6,366			6,366	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,434,184	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,434,184	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	386,384	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,009,455	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,395,839	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,395,839	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,395,839	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,830,023	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 8/2/2021 2:11 pm

RHC III

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	8.67	26,017	1	9		1.00
2.00	Physician Assistant	0.95	2,592	1	1		2.00
3.00	Nurse Practitioner	9.35	18,190	1	9		3.00
4.00	Subtotal (sum of lines 1 through 3)	18.97	46,799		19	46,799	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	0.98	17			17	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)	19.95	46,816			46,816	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)					7,523,598	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					7,523,598	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,228,413	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					5,922,658	15.00
16.00	Total overhead (sum of lines 14 and 15)					9,151,071	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					9,151,071	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					9,151,071	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					16,674,669	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	RHC I	

		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)	5,073,445	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	714,778	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	4,358,667	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	17,751	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)	17,751	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	245.54	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	245.54	245.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	45	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	11,049	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	11,049	16.00
16.01	Total program charges (see instructions)(from contractor's records)		8,060	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		8,522	16.04
16.05	Total program cost (see instructions)	0	8,522	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		396	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,533	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		8,522	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		8,522	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)		8,522	26.00
26.01	Sequestration adjustment (see instructions)		56	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		6,358	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)		2,108	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	RHC II	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,830,023	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		12,263	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,817,760	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,366	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)		6,366	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		442.63	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	442.63	442.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	235	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	104,018	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	104,018	16.00
16.01	Total program charges (see instructions)(from contractor's records)		45,251	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,196	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,437	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.)		62,750	16.04
16.05	Total program cost (see instructions)	0	86,187	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,144	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,582	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		86,187	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		86,187	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)		86,187	26.00
26.01	Sequestration adjustment (see instructions)		569	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		60,162	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)		25,456	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	RHC III	

			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)		16,674,669	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		754,743	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		15,919,926	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		46,816	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)		46,816	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		340.05	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	340.05	340.05	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	12,135	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	4,126,507	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	4,126,507	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,784,859	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		409,692	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		607,067	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.)		2,656,066	16.04
16.05	Total program cost (see instructions)	0	3,263,133	16.05
17.00	Primary payer amounts		46	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		199,358	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		430,207	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		3,263,087	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		239,777	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,502,864	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)		3,502,864	26.00
26.01	Sequestration adjustment (see instructions)		23,119	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		2,462,088	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)		1,017,657	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: 15-0097 Component CCN: 15-8529	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	RHC I	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,224,105	2,224,105	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.009618	0.006913	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	21,391	15,375	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	249,369	88,811	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	270,760	104,186	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,661,335	2,661,335	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,412,110	2,412,110	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.101738	0.039148	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	245,403	94,429	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	516,163	198,615	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2,510	1,804	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	205.64	110.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	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)		714,778	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)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 2:11 pm
	Title XVIII	RHC II	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,100,281	1,100,281	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000906	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	997	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	5,218	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	6,215	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,434,184	1,434,184	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,395,839	1,395,839	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.004333	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	6,048	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	12,263	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	106	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	115.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	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)		12,263	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)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-4 | Date/Time Prepared: 8/2/2021 2:11 pm

Title XVIII | RHC III

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	6,631,880	6,631,880	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001401	0.004859	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	9,291	32,224	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	109,980	189,043	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	119,271	221,267	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	7,523,598	7,523,598	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	9,151,071	9,151,071	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015853	0.029410	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	145,072	269,133	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	264,343	490,400	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,088	3,800	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	242.96	129.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	409	1,088	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	99,371	140,406	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)		754,743	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)		239,777	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 2:11 pm
		RHC I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		6,358	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)		6,358	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		2,108	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		8,466	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 2:11 pm
		RHC II	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		60,162	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)		60,162	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		25,456	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		85,618	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 2:11 pm
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,254,688	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		08/31/2020	207,400	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)		207,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,462,088	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		1,017,657	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,479,745	7.00

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