

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: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 10:57 am
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PART I - COST REPORT STATUS

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

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

Date: 8/2/2021 Time: 10:57 am

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 MEMORIAL HOSPITAL LOGANSPO RT (15-0072) 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.

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) SHERRI GEHLHAUSEN
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-65,521	9,962	0	283,352	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0	0	0		0	6.00
200.00 Total	0	-65,521	9,962	0	283,352	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: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:57 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1101 MICHIGAN AVENUE	PO Box:							1.00	
2.00	City: LOGANSPORT	State: IN		Zip Code: 46947-		County: CASS			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	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	MEMORIAL HOSPITAL LOGANSPORT	150072	99915	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	SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2020	12/31/2020		20.00	
21.00	Type of Control (see instructions)					9			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.	322	0	0	0	824	0		24.00	

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
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	0	25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		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.					01/01/2020	12/31/2020	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	N	40.00	
		V		XVII		XIX			
		1.00		2.00		3.00			
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
		NAHE 413.85 Y/N		Worksheet A Line #		Pass-Through Qualification Criteria Code			
		1.00		2.00		3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:57 am	
		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
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	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:	641,268		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	Y	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.				N	122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N	125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:57 am	
		1.00	2.00				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:		Zip Code:		142.00	
143.00	City:	State:				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	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	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	
						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: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:57 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 10:57 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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					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	02/24/2021	Y	02/24/2021		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: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 10:57 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			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.			N	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.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 10:57 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		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: 15-0072

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

Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 10:57 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	32	11,712	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)		32	11,712	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,830	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		37	13,542	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		37				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)		5	1,830			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: 15-0072

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

Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 10:57 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	1,343	322	4,262			1.00
2.00 HMO and other (see instructions)	718	824				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)	1,343	322	4,262			7.00
8.00 INTENSIVE CARE UNIT	166	0	455			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	985			13.00
14.00 Total (see instructions)	1,509	322	5,702	0.00	533.15	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	533.15	27.00
28.00 Observation Bed Days		20	954			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	316			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: 15-0072

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

Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 10:57 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	459	131	1,501	1.00
2.00 HMO and other (see instructions)				182	406		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	459		131	1,501	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

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

Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 10:57 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	39,216,701	-247,481	38,969,220	1,123,746.00	34.68
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthesiologist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		289,092	0	289,092	1,385.00	208.73
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		7,828,305	0	7,828,305	53,158.00	147.26
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,115,158	-33,164	7,081,994	157,963.00	44.83
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		4,139,863	0	4,139,863	55,160.00	75.05
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		97,097	0	97,097	1,111.00	87.40
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,383,767	0	8,383,767		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,527,638	0	1,527,638		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		0	0	0		
22.00	Physician Part A - Administrative		23,121	0	23,121		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		811,208	0	811,208		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

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

Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 10:57 am

	Wkst. A Line Number	Amount Reported	Recl assi fi cat ion 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	348,157	0	348,157	10,879.00	32.00	26.00
27.00	Administrative & General	3,513,679	-10,849	3,502,830	186,693.00	18.76	27.00
28.00	Administrative & General under contract (see inst.)	289,016	0	289,016	1,221.00	236.70	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	790,318	-6,620	783,698	25,663.00	30.54	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	656,326	-3,537	652,789	40,831.00	15.99	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	448,745	-367,836	80,909	5,730.00	14.12	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	367,836	367,836	23,637.00	15.56	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,028,944	0	1,028,944	22,304.00	46.13	38.00
39.00	Central Services and Supply	292,147	-1,334	290,813	16,944.00	17.16	39.00
40.00	Pharmacy	573,124	-11,219	561,905	16,674.00	33.70	40.00
41.00	Medical Records & Medical Records Library	1,745,597	-21,134	1,724,463	38,181.00	45.17	41.00
42.00	Social Service	179,176	0	179,176	4,300.00	41.67	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

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

Worksheet S-3
Part III
Date/Time Prepared:
8/2/2021 10:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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)	31,677,412	-247,481	31,429,931	1,071,809.00	29.32	1.00
2.00	Excluded area salaries (see instructions)	7,115,158	-33,164	7,081,994	157,963.00	44.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24,562,254	-214,317	24,347,937	913,846.00	26.64	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,236,960	0	4,236,960	56,271.00	75.30	4.00
5.00	Subtotal wage-related costs (see inst.)	8,406,888	0	8,406,888	0.00	34.53	5.00
6.00	Total (sum of lines 3 thru 5)	37,206,102	-214,317	36,991,785	970,117.00	38.13	6.00
7.00	Total overhead cost (see instructions)	9,865,229	-54,693	9,810,536	393,057.00	24.96	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 10:57 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	426,007	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,847,263	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	146,225	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	50,982	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)	431,874	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	194,462	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	2,544,541	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	53,231	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	24,149	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,718,734	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: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part V Date/Time Prepared: 8/2/2021 10:57 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	4,139,863	10,745,426	1.00
2.00	Hospital	4,139,863	10,745,426	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 8/2/2021 10:57 am
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			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)		0.337697	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,095,372	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		34,655,257	6.00	
7.00	Medicaid cost (line 1 times line 6)		11,702,976	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)		4,607,604	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)		4,607,604	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)	744,765	572,552	1,317,317	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	251,505	572,552	824,057	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)	251,505	572,552	824,057	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)		10,847,420	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		119,947	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		184,535	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		10,662,885	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,665,412	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,489,469	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		9,097,073	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet A Date/Time Prepared: 8/2/2021 10:57 am
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,620,741		4,623,885
1.01	00101	MOB		0	223,692	223,692
1.02	00102	OPS		0	147,326	147,326
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	348,157	10,935,680	-1,375	11,282,462
5.00	00500	ADMINISTRATIVE & GENERAL	3,513,679	7,015,792	1,515	10,530,986
7.00	00700	OPERATION OF PLANT	790,318	1,854,575	237,364	2,882,257
8.00	00800	LAUNDRY & LINEN SERVICE	0	185,556	0	185,556
9.00	00900	HOUSEKEEPING	656,326	191,787	0	848,113
10.00	01000	DIETARY	448,745	333,857	-641,499	141,103
11.00	01100	CAFETERIA	0	0	641,499	641,499
13.00	01300	NURSING ADMINISTRATION	1,028,944	297,715	428,094	1,754,753
14.00	01400	CENTRAL SERVICES & SUPPLY	292,147	219,872	-37,837	474,182
15.00	01500	PHARMACY	573,124	670,733	0	1,243,857
16.00	01600	MEDICAL RECORDS & LIBRARY	1,745,597	4,740,914	0	6,486,511
17.00	01700	SOCIAL SERVICE	179,176	14,537	0	193,713
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,230,489	563,121	-763,140	4,030,470
31.00	03100	INTENSIVE CARE UNIT	768,111	111,287	0	879,398
43.00	04300	NURSERY	0	341	316,529	316,870
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,089,310	1,613,916	0	6,703,226
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	152	446,611	446,763
53.00	05300	ANESTHESIOLOGY	0	1,724,712	0	1,724,712
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,847	648,609	0	1,860,456
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	3,815,109	0	3,815,109
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	118,703	0	118,703
65.00	06500	RESPIRATORY THERAPY	892,036	107,069	0	999,105
66.00	06600	PHYSICAL THERAPY	866,453	55,224	0	921,677
69.00	06900	ELECTROCARDIOLOGY	354,445	103,256	0	457,701
69.01	06901	CARDIAC REHAB	283,938	16,691	0	300,629
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,501,301	-1,312,824	2,188,477
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,312,824	1,312,824
73.00	07300	DRUGS CHARGED TO PATIENTS	2	9,244,106	0	9,244,108
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	232,938	392,875	0	625,813
76.01	03480	ONCOLOGY	676,825	2,048,020	0	2,724,845
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,017,109	887,694	-1,923	6,902,880
90.01	09001	WOUND CARE	165,914	610,543	0	776,457
91.00	09100	EMERGENCY	1,735,913	915,156	0	2,651,069
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,101,543	58,559,644	90,661,187	90,661,187
NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	1,947	0	1,947
194.01	07951	MOB	0	87	0	87
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0
194.03	07953	PIH	0	0	0	0
194.04	07954	HEALTH COMPANIES	502,460	160,528	0	662,988
194.05	07955	PHYSICIANS OFFICE	4,506,592	847,564	0	5,354,156
194.06	07956	THE ARBORS	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	0	0
194.08	07958	OPS	0	0	0	0
194.09	07959	MHL ROCHESTER HEALTH CENTER	189,669	150,630	0	340,299
194.10	07961	RHEUMATOLOGY	1,446,951	15,435	0	1,462,386
194.11	07960	SPORTS HEALTH	323,403	39,149	0	362,552
194.12	07962	BEHAVIORAL HEALTH CLINIC	146,083	16,684	0	162,767
200.00		TOTAL (SUM OF LINES 118 through 199)	39,216,701	59,791,668	99,008,369	99,008,369

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0072

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

Worksheet A
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-95,884	4,528,001	1.00
1.01	00101 MOB	0	223,692	1.01
1.02	00102 OPS	0	147,326	1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3,455	11,279,007	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3,931,608	6,599,378	5.00
7.00	00700 OPERATION OF PLANT	-15,185	2,867,072	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	185,556	8.00
9.00	00900 HOUSEKEEPING	0	848,113	9.00
10.00	01000 DIETARY	-14,744	126,359	10.00
11.00	01100 CAFETERIA	-1,739	639,760	11.00
13.00	01300 NURSING ADMINISTRATION	-1,708	1,753,045	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-41,563	432,619	14.00
15.00	01500 PHARMACY	0	1,243,857	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-24,899	6,461,612	16.00
17.00	01700 SOCIAL SERVICE	-751	192,962	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-940,885	3,089,585	30.00
31.00	03100 INTENSIVE CARE UNIT	0	879,398	31.00
43.00	04300 NURSERY	0	316,870	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-3,583,750	3,119,476	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	446,763	52.00
53.00	05300 ANESTHESIOLOGY	-1,696,178	28,534	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,860,456	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	3,815,109	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	118,703	63.00
65.00	06500 RESPIRATORY THERAPY	0	999,105	65.00
66.00	06600 PHYSICAL THERAPY	0	921,677	66.00
69.00	06900 ELECTROCARDIOLOGY	0	457,701	69.00
69.01	06901 CARDIAC REHAB	0	300,629	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,188,477	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,312,824	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-132,825	9,111,283	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	625,813	76.00
76.01	03480 ONCOLOGY	-1,464,926	1,259,919	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-4,889,026	2,013,854	90.00
90.01	09001 WOUND CARE	-604,600	171,857	90.01
91.00	09100 EMERGENCY	-755,986	1,895,083	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-18,199,712	72,461,475	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950 FOUNDATION	0	1,947	194.00
194.01	07951 MOB	0	87	194.01
194.02	07952 NONREIMBURSABLE OTHER	0	0	194.02
194.03	07953 PIH	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	662,988	194.04
194.05	07955 PHYSICIANS OFFICE	0	5,354,156	194.05
194.06	07956 THE ARBORS	0	0	194.06
194.07	07957 PAIN MANAGEMENT	0	0	194.07
194.08	07958 OPS	0	0	194.08
194.09	07959 MHL ROCHESTER HEALTH CENTER	0	340,299	194.09
194.10	07961 RHEUMATOLOGY	0	1,462,386	194.10
194.11	07960 SPORTS HEALTH	0	362,552	194.11
194.12	07962 BEHAVIORAL HEALTH CLINIC	0	162,767	194.12
200.00	TOTAL (SUM OF LINES 118 through 199)	-18,199,712	80,808,657	200.00

RECLASSIFICATIONS

Provider CCN: 15-0072

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

Worksheet A-6

Date/Time Prepared:
8/2/2021 10:57 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	367,836	273,663	1.00	
	O		367,836	273,663		
B - OB RECLASS						
1.00	NURSERY	43.00	286,690	29,839	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	404,211	42,400	2.00	
	O		690,901	72,239		
C - MALPRACTICE INS. RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	625,838	1.00	
	O		0	625,838		
D - IMPLANT EXPENSE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,312,824	1.00	
	O		0	1,312,824		
E - UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	237,364	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	O		0	237,364		
G - DEPRECIATION RECLASS						
1.00	MOB	1.01	0	223,692	1.00	
2.00	OPS	1.02	0	147,326	2.00	
	TOTALS		0	371,018		
H - COVID-19 SUPPLY RECLASS						
1.00	NURSING ADMINISTRATION	13.00	0	428,094	1.00	
	TOTALS		0	428,094		
I - SHORT TERM DISABILITY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,849	1.00	
2.00	OPERATION OF PLANT	7.00	0	6,620	2.00	
3.00	HOUSEKEEPING	9.00	0	3,537	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,334	4.00	
5.00	PHARMACY	15.00	0	11,219	5.00	
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	21,134	6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	60,230	7.00	
8.00	INTENSIVE CARE UNIT	31.00	0	3,521	8.00	
9.00	OPERATING ROOM	50.00	0	32,363	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,920	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	11,534	11.00	
12.00	ONCOLOGY	76.01	0	16,725	12.00	
13.00	CLINIC	90.00	0	29,686	13.00	
14.00	EMERGENCY	91.00	0	645	14.00	
15.00	PHYSICIANS OFFICE	194.05	0	12,446	15.00	
16.00	MHL ROCHESTER HEALTH CENTER	194.09	0	12,602	16.00	
17.00	SPORTS HEALTH	194.11	0	4,541	17.00	
18.00	BEHAVIORAL HEALTH CLINIC	194.12	0	3,575	18.00	
	TOTALS		0	247,481		
500.00	Grand Total: Increases		1,058,737	3,568,521	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0072

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

Worksheet A-6

Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	367,836	273,663	0		1.00
	O		367,836	273,663			
B - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	690,901	72,239	0		1.00
2.00		0.00	0	0	0		2.00
	O		690,901	72,239			
C - MALPRACTICE INS. RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	625,838	12		1.00
	O		0	625,838			
D - IMPLANT EXPENSE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,312,824	0		1.00
	O		0	1,312,824			
E - UTILITIES RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,375	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	196,229	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	37,837	0		3.00
4.00	CLINIC	90.00	0	1,923	0		4.00
	O		0	237,364			
G - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	371,018	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	371,018			
H - COVID-19 SUPPLY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	428,094	0		1.00
	TOTALS		0	428,094			
I - SHORT TERM DISABILITY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	10,849	0	0		1.00
2.00	OPERATION OF PLANT	7.00	6,620	0	0		2.00
3.00	HOUSEKEEPING	9.00	3,537	0	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	1,334	0	0		4.00
5.00	PHARMACY	15.00	11,219	0	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	21,134	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	60,230	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	3,521	0	0		8.00
9.00	OPERATING ROOM	50.00	32,363	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	4,920	0	0		10.00
11.00	RESPIRATORY THERAPY	65.00	11,534	0	0		11.00
12.00	ONCOLOGY	76.01	16,725	0	0		12.00
13.00	CLINIC	90.00	29,686	0	0		13.00
14.00	EMERGENCY	91.00	645	0	0		14.00
15.00	PHYSICIANS OFFICE	194.05	12,446	0	0		15.00
16.00	MHL ROCHESTER HEALTH CENTER	194.09	12,602	0	0		16.00
17.00	SPORTS HEALTH	194.11	4,541	0	0		17.00
18.00	BEHAVIORAL HEALTH CLINIC	194.12	3,575	0	0		18.00
	TOTALS		247,481	0			
500.00	Grand Total: Decreases		1,306,218	3,321,040			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

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

Worksheet A-7
Part I
Date/Time Prepared:
8/2/2021 10:57 am

	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	205,783	0	0	0	1.00
2.00	Land Improvements	838,517	0	0	0	2.00
3.00	Buildings and Fixtures	64,633,987	410,000	0	410,000	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	7,611,191	0	7,611,191	5.00
6.00	Movable Equipment	46,864,773	2,008,134	0	2,008,134	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	112,543,060	10,029,325	0	10,029,325	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	112,543,060	10,029,325	0	10,029,325	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	205,783	0			1.00
2.00	Land Improvements	838,517	0			2.00
3.00	Buildings and Fixtures	65,043,987	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	7,611,191	0			5.00
6.00	Movable Equipment	48,872,907	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	122,572,385	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	122,572,385	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

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

Worksheet A-7
Part II
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,100,744	0	788,175	731,822	0	1.00
1.01	MOB	0	0	0	0	0	1.01
1.02	OPS	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	4,100,744	0	788,175	731,822	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,620,741				1.00
1.01	MOB	0	0				1.01
1.02	OPS	0	0				1.02
3.00	Total (sum of lines 1-2)	0	5,620,741				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

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

Worksheet A-7
Part III
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	122,463,783	0	122,463,783	1.000000	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	OPS	0	0	0	0.000000	0	1.02
3.00	Total (sum of lines 1-2)	122,463,783	0	122,463,783	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,702,670	0	1.00
1.01	MOB	0	0	0	223,692	0	1.01
1.02	OPS	0	0	0	147,326	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	4,073,688	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	719,347	105,984	0	0	4,528,001	1.00
1.01	MOB	0	0	0	0	223,692	1.01
1.02	OPS	0	0	0	0	147,326	1.02
3.00	Total (sum of lines 1-2)	719,347	105,984	0	0	4,899,019	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0072

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - MOB (chapter 2)			OMOB	1.01	0	1.01
1.02 Investment income - OPS (chapter 2)			OOPS	1.02	0	1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00 Television and radio service (chapter 21)			0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-13,916,223			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00 Laundry and linen service			0	0.00	0	13.00
14.00 Cafeteria-employees and guests	A	-3	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others			0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00 Sale of drugs to other than patients			0	0.00	0	17.00
18.00 Sale of medical records and abstracts			0	0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00 Vending machines			0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - MOB			OMOB	1.01	0	26.01
26.02 Depreciation - OPS			OOPS	1.02	0	26.02
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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0072

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 OTHER REVENUE - BAD DEBT	B	-84	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 OTHER REVENUE - MEDICARE	B	-49,537	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 OTHER REVENUE - BLUE CROSS	B	-7,279	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00 OTHER REVENUE - MEDICAID	B	-1,182	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 OTHER REVENUE - SCRAP SAL	B	-1,414	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 OTHER REVENUE - CASH OVER	B	-2,566	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 MHL A/P DISCOUNTS	B	1,808	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 MEALS ON WHEELS	B	-1,733	CAFETERIA	11.00	0	41.00
45.00 OTHER REVENUE - CAFETERIA SALES	B	-3	CAFETERIA	11.00	0	45.00
45.01 OTHER REVENUE - CPR TRAINING	B	-1,708	NURSING ADMINISTRATION	13.00	0	45.01
45.02 OTHER REVENUE - REBATES MMT	B	-41,563	CENTRAL SERVICES & SUPPLY	14.00	0	45.02
45.03 HIM MEDICAL RECORDS FEES	B	-24,899	MEDICAL RECORDS & LIBRARY	16.00	0	45.03
45.04 340B OFFSET	A	-132,825	DRUGS CHARGED TO PATIENTS	73.00	0	45.04
45.05 INTEREST INCOME	B	-68,828	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.05
45.06 DIETARY REVENUE	B	-14,744	DIETARY	10.00	0	45.06
45.07 PATIENT TELEVISIONS	A	-1,524	OPERATION OF PLANT	7.00	0	45.07
45.08 PATIENT TELEPHONES	A	-3,455	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.08
45.09 PATIENT TELEPHONES	A	-2,138	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.09
45.10 PATIENT TELEPHONES	A	-1,573	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.12 IHA & AHA LOBBYING FEES	A	-8,304	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13 GIFT SHOP	A	-21,604	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.14 GIFT SHOP	A	-11,844	OPERATION OF PLANT	7.00	0	45.14
45.15 ADVERTISING	A	-895,035	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16 TAXES	A	-30,942	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17 DONATION EXPENSE	A	-83,303	ADMINISTRATIVE & GENERAL	5.00	0	45.17
45.18 PHYSICIAN RECRUITMENT	A	-299,212	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19 VENDING	A	-3,314	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.19
45.20 VENDING	A	-1,817	OPERATION OF PLANT	7.00	0	45.20
45.21 HOSPITAL ASSESSMENT FEE OFFSET	A	-2,552,985	ADMINISTRATIVE & GENERAL	5.00	0	45.21
45.23 HOSPITALIST OFFSET	A	-19,879	ADULTS & PEDIATRICS	30.00	0	45.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,199,712				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0072

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

Worksheet A-8-2

Date/Time Prepared:
8/2/2021 10:57 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	33,316	0	33,316	211,500	389	1.00
2.00	17.00	SOCIAL SERVICE	6,750	0	6,750	211,501	59	2.00
3.00	30.00	ADULTS & PEDIATRICS	942,973	921,006	21,967	211,500	255	3.00
4.00	50.00	OPERATING ROOM	3,692,379	3,459,796	232,583	246,400	917	4.00
5.00	53.00	ANESTHESIOLOGY	1,696,178	1,696,178	0	211,500	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	35,064	0	35,064	211,500	407	6.00
7.00	76.01	ONCOLOGY	1,464,926	1,464,926	0	211,500	0	7.00
8.00	90.00	CLINIC	4,936,614	4,850,392	86,222	211,500	468	8.00
9.00	90.01	WOUND CARE	604,600	604,600	0	211,500	0	9.00
10.00	91.00	EMERGENCY	755,986	755,986	0	211,500	0	10.00
200.00			14,168,786	13,752,884	415,902		2,495	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	39,555	1,978	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	5,999	300	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	25,929	1,296	0	0	0	3.00
4.00	50.00	OPERATING ROOM	108,629	5,431	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	41,385	2,069	0	0	0	6.00
7.00	76.01	ONCOLOGY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	47,588	2,379	0	0	0	8.00
9.00	90.01	WOUND CARE	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			269,085	13,453	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	39,555	0	0		1.00
2.00	17.00	SOCIAL SERVICE	0	5,999	751	751		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	25,929	0	921,006		3.00
4.00	50.00	OPERATING ROOM	0	108,629	123,954	3,583,750		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,696,178		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	41,385	0	0		6.00
7.00	76.01	ONCOLOGY	0	0	0	1,464,926		7.00
8.00	90.00	CLINIC	0	47,588	38,634	4,889,026		8.00
9.00	90.01	WOUND CARE	0	0	0	604,600		9.00
10.00	91.00	EMERGENCY	0	0	0	755,986		10.00
200.00			0	269,085	163,339	13,916,223		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT		
		NEW BLDG & FIXT	MOB	OPS			
		1.00	1.01	1.02			4.00
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	4,528,001	4,528,001				1.00	
1.01 00101 MOB	223,692	0	223,692			1.01	
1.02 00102 OPS	147,326	0	0	147,326		1.02	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11,279,007	8,983	0	0	11,287,990	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	6,599,378	367,418	20,990	0	1,023,790	5.00	
7.00 00700 OPERATION OF PLANT	2,867,072	837,314	1,359	11,704	229,055	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	185,556	14,673	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	848,113	32,850	726	432	190,794	9.00	
10.00 01000 DIETARY	126,359	139,043	0	0	23,648	10.00	
11.00 01100 CAFETERIA	639,760	67,205	0	0	107,509	11.00	
13.00 01300 NURSING ADMINISTRATION	1,753,045	52,132	0	0	300,735	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	432,619	97,045	0	0	84,997	14.00	
15.00 01500 PHARMACY	1,243,857	49,452	0	0	164,231	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	6,461,612	175,067	0	0	504,017	16.00	
17.00 01700 SOCIAL SERVICE	192,962	29,205	0	0	52,369	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	3,089,585	819,231	0	0	1,016,929	30.00	
31.00 03100 INTENSIVE CARE UNIT	879,398	124,228	0	0	223,471	31.00	
43.00 04300 NURSERY	316,870	6,114	0	0	83,792	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,119,476	458,232	0	33,560	1,478,019	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	446,763	100,243	0	0	118,141	52.00	
53.00 05300 ANESTHESIOLOGY	28,534	41,457	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,860,456	212,291	0	8,309	352,755	54.00	
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	3,815,109	113,741	6,874	3,875	0	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	118,703	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	999,105	8,089	0	0	257,349	65.00	
66.00 06600 PHYSICAL THERAPY	921,677	89,826	0	0	253,243	66.00	
69.00 06900 ELECTROCARDIOLOGY	457,701	11,264	14,463	0	103,595	69.00	
69.01 06901 CARDIAC REHAB	300,629	130,813	0	0	82,988	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,188,477	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,312,824	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	9,111,283	0	0	0	1	73.00	
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	625,813	17,236	0	0	68,082	76.00	
76.01 03480 ONCOLOGY	1,259,919	0	22,395	48,216	192,931	76.01	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	2,013,854	4,938	80,990	0	1,749,991	90.00	
90.01 09001 WOUND CARE	171,857	0	13,993	0	48,493	90.01	
91.00 09100 EMERGENCY	1,895,083	360,270	0	0	507,175	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	72,461,475	4,368,360	161,790	106,096	9,218,100	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950 FOUNDATION	1,947	0	0	0	0	194.00	
194.01 07951 MOB	87	0	7,569	0	0	194.01	
194.02 07952 NONREIMBURSABLE OTHER	0	0	0	0	0	194.02	
194.03 07953 PIH	0	0	0	0	0	194.03	
194.04 07954 HEALTH COMPANIES	662,988	53,731	0	0	146,856	194.04	
194.05 07955 PHYSICIANS OFFICE	5,354,156	105,910	18,266	0	1,313,527	194.05	
194.06 07956 THE ARBORS	0	0	0	0	0	194.06	
194.07 07957 PAIN MANAGEMENT	0	0	7,186	0	0	194.07	
194.08 07958 OPS	0	0	0	41,230	0	194.08	
194.09 07959 MHL ROCHESTER HEALTH CENTER	340,299	0	0	0	51,752	194.09	
194.10 07961 RHEUMATOLOGY	1,462,386	0	28,881	0	422,908	194.10	
194.11 07960 SPORTS HEALTH	362,552	0	0	0	93,195	194.11	
194.12 07962 BEHAVIORAL HEALTH CLINIC	162,767	0	0	0	41,652	194.12	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118 through 201)	80,808,657	4,528,001	223,692	147,326	11,287,990	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,011,576	8,011,576			5.00
7.00	00700	OPERATION OF PLANT	3,946,504	434,329	4,380,833		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200,229	22,036	13,284	235,549	8.00
9.00	00900	HOUSEKEEPING	1,072,915	118,079	34,487	0	1,225,481
10.00	01000	DIETARY	289,050	31,811	125,876	945	0
11.00	01100	CAFETERIA	814,474	89,636	60,841	0	0
13.00	01300	NURSING ADMINISTRATION	2,105,912	231,764	47,196	0	3,325
14.00	01400	CENTRAL SERVICES & SUPPLY	614,661	67,646	87,856	0	7,979
15.00	01500	PHARMACY	1,457,540	160,408	44,769	0	6,649
16.00	01600	MEDICAL RECORDS & LIBRARY	7,140,696	785,862	158,490	0	9,974
17.00	01700	SOCIAL SERVICE	274,536	30,214	26,440	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,925,745	542,098	741,655	63,458	410,266
31.00	03100	INTENSIVE CARE UNIT	1,227,097	135,047	112,465	8,285	66,494
43.00	04300	NURSERY	406,776	44,767	5,535	14,666	2,660
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,089,287	560,096	548,892	70,679	149,611
52.00	05200	DELIVERY ROOM & LABOR ROOM	665,147	73,202	90,751	0	45,881
53.00	05300	ANESTHESIOLOGY	69,991	7,703	37,531	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,433,811	267,851	225,377	17,116	53,195
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,939,599	433,569	147,079	0	23,273
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,703	13,064	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,264,543	139,168	7,323	0	29,922
66.00	06600	PHYSICAL THERAPY	1,264,746	139,190	81,320	1,378	13,299
69.00	06900	ELECTROCARDIOLOGY	587,023	64,604	70,442	0	29,922
69.01	06901	CARDIAC REHAB	514,430	56,615	118,426	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,188,477	240,851	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,312,824	144,482	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	9,111,284	1,002,697	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	711,131	78,263	15,604	0	0
76.01	03480	ONCOLOGY	1,523,461	167,663	285,878	0	53,195
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,849,773	423,683	341,823	0	36,572
90.01	09001	WOUND CARE	234,343	25,790	58,287	0	16,623
91.00	09100	EMERGENCY	2,762,528	304,027	326,155	59,022	106,390
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,128,812	6,836,215	3,813,782	235,549	1,065,230
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	1,947	214	0	0	10,639
194.01	07951	MOB	7,656	843	31,528	0	0
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	863,575	95,040	48,643	0	13,299
194.05	07955	PHYSICIANS OFFICE	6,791,859	747,471	171,965	0	79,793
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	7,186	791	29,931	0	0
194.08	07958	OPS	41,230	4,538	164,685	0	26,598
194.09	07959	MHL ROCHESTER HEALTH CENTER	392,051	43,147	0	0	0
194.10	07961	RHEUMATOLOGY	1,914,175	210,663	120,299	0	29,922
194.11	07960	SPORTS HEALTH	455,747	50,157	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	204,419	22,497	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	80,808,657	8,011,576	4,380,833	235,549	1,225,481

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 OPS						1.02
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	447,682					10.00
11.00	01100 CAFETERIA	0	964,951				11.00
13.00	01300 NURSING ADMINISTRATION	0	48,571	2,436,768			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2,375	0	780,517		14.00
15.00	01500 PHARMACY	0	18,363	0	0	1,687,729	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	271	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	17,346	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	404,499	123,813	946,875	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	43,183	27,080	207,095	0	0	31.00
43.00	04300 NURSERY	0	9,019	68,977	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	86,597	662,256	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	12,718	97,258	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	44,445	0	0	0	54.00
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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	22,190	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	30,174	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	9,386	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	14,052	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	780,517	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	1,687,729	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	6,879	0	0	0	76.00
76.01	03480 ONCOLOGY	0	18,723	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	161,102	0	0	0	90.00
90.01	09001 WOUND CARE	0	25,709	0	0	0	90.01
91.00	09100 EMERGENCY	0	59,405	454,307	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	447,682	738,218	2,436,768	780,517	1,687,729	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950 FOUNDATION	0	0	0	0	0	194.00
194.01	07951 MOB	0	0	0	0	0	194.01
194.02	07952 NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953 PIH	0	0	0	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	32,705	0	0	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	61,954	0	0	0	194.05
194.06	07956 THE ARBORS	0	0	0	0	0	194.06
194.07	07957 PAIN MANAGEMENT	0	2,568	0	0	0	194.07
194.08	07958 OPS	0	0	0	0	0	194.08
194.09	07959 MHL ROCHESTER HEALTH CENTER	0	20,499	0	0	0	194.09
194.10	07961 RHEUMATOLOGY	0	32,508	0	0	0	194.10
194.11	07960 SPORTS HEALTH	0	10,977	0	0	0	194.11
194.12	07962 BEHAVIORAL HEALTH CLINIC	0	65,522	0	0	0	194.12
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	447,682	964,951	2,436,768	780,517	1,687,729	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 8/2/2021 10:57 am
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
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	8,095,293				16.00
17.00	01700	SOCIAL SERVICE	0	348,536			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	561,128	268,264	8,987,801	0	8,987,801
31.00	03100	INTENSIVE CARE UNIT	103,558	26,449	1,956,753	0	1,956,753
43.00	04300	NURSERY	65,387	0	617,787	0	617,787
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,149,390	1,295	9,318,103	0	9,318,103
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,191	0	1,077,148	0	1,077,148
53.00	05300	ANESTHESIOLOGY	97,219	0	212,444	0	212,444
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,696	0	3,689,491	0	3,689,491
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	962,129	0	5,505,649	0	5,505,649
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	55,766	0	187,533	0	187,533
65.00	06500	RESPIRATORY THERAPY	313,824	0	1,776,970	0	1,776,970
66.00	06600	PHYSICAL THERAPY	169,605	0	1,699,712	0	1,699,712
69.00	06900	ELECTROCARDIOLOGY	132,035	0	893,412	0	893,412
69.01	06901	CARDIAC REHAB	19,798	0	723,321	0	723,321
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,209,845	0	3,209,845
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,457,306	0	1,457,306
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,801,710	0	11,801,710
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	495,580	0	1,307,457	0	1,307,457
76.01	03480	ONCOLOGY	527,430	0	2,576,350	0	2,576,350
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	496,378	30,333	5,339,664	0	5,339,664
90.01	09001	WOUND CARE	119,497	0	480,249	0	480,249
91.00	09100	EMERGENCY	707,090	22,195	4,801,119	0	4,801,119
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,715,701	348,536	67,619,824	0	67,619,824
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	12,800	0	12,800
194.01	07951	MOB	0	0	40,027	0	40,027
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	0	0	1,053,262	0	1,053,262
194.05	07955	PHYSICIANS OFFICE	288,757	0	8,141,799	0	8,141,799
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	40,476	0	40,476
194.08	07958	OPS	0	0	237,051	0	237,051
194.09	07959	MHL ROCHESTER HEALTH CENTER	8,548	0	464,245	0	464,245
194.10	07961	RHEUMATOLOGY	68,307	0	2,375,874	0	2,375,874
194.11	07960	SPORTS HEALTH	0	0	516,881	0	516,881
194.12	07962	BEHAVIORAL HEALTH CLINIC	13,980	0	306,418	0	306,418
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	8,095,293	348,536	80,808,657	0	80,808,657

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0072

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

Worksheet B
Part II
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	MOB	OPS		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	MOB					1.01
1.02 00102	OPS					1.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,983	0	0	8,983 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	367,418	20,990	0	388,408 5.00
7.00 00700	OPERATION OF PLANT	0	837,314	1,359	11,704	850,377 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	14,673	0	0	14,673 8.00
9.00 00900	HOUSEKEEPING	0	32,850	726	432	34,008 9.00
10.00 01000	DIETARY	0	139,043	0	0	139,043 10.00
11.00 01100	CAFETERIA	0	67,205	0	0	67,205 11.00
13.00 01300	NURSING ADMINISTRATION	0	52,132	0	0	52,132 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	97,045	0	0	97,045 14.00
15.00 01500	PHARMACY	0	49,452	0	0	49,452 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	175,067	0	0	175,067 16.00
17.00 01700	SOCIAL SERVICE	0	29,205	0	0	29,205 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	819,231	0	0	819,231 30.00
31.00 03100	INTENSIVE CARE UNIT	0	124,228	0	0	124,228 31.00
43.00 04300	NURSERY	0	6,114	0	0	6,114 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	458,232	0	33,560	491,792 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	100,243	0	0	100,243 52.00
53.00 05300	ANESTHESIOLOGY	0	41,457	0	0	41,457 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	212,291	0	8,309	220,600 54.00
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	113,741	6,874	3,875	124,490 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	0	8,089	0	0	8,089 65.00
66.00 06600	PHYSICAL THERAPY	0	89,826	0	0	89,826 66.00
69.00 06900	ELECTROCARDIOLOGY	0	11,264	14,463	0	25,727 69.00
69.01 06901	CARDIAC REHAB	0	130,813	0	0	130,813 69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	17,236	0	0	17,236 76.00
76.01 03480	ONCOLOGY	0	0	22,395	48,216	70,611 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	4,938	80,990	0	85,928 90.00
90.01 09001	WOUND CARE	0	0	13,993	0	13,993 90.01
91.00 09100	EMERGENCY	0	360,270	0	0	360,270 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	4,368,360	161,790	106,096	4,636,246 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	FOUNDATION	0	0	0	0	0 194.00
194.01 07951	MOB	0	0	7,569	0	7,569 194.01
194.02 07952	NONREIMBURSABLE OTHER	0	0	0	0	0 194.02
194.03 07953	PIH	0	0	0	0	0 194.03
194.04 07954	HEALTH COMPANIES	0	53,731	0	0	53,731 194.04
194.05 07955	PHYSICIANS OFFICE	0	105,910	18,266	0	124,176 194.05
194.06 07956	THE ARBORS	0	0	0	0	0 194.06
194.07 07957	PAIN MANAGEMENT	0	0	7,186	0	7,186 194.07
194.08 07958	OPS	0	0	0	41,230	41,230 194.08
194.09 07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0 194.09
194.10 07961	RHEUMATOLOGY	0	0	28,881	0	28,881 194.10
194.11 07960	SPORTS HEALTH	0	0	0	0	0 194.11
194.12 07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 194.12
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	4,528,001	223,692	147,326	4,899,019 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 10:57 am		
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		4.00	5.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	MOB					1.01	
1.02	00102	OPS					1.02	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,983				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	816	389,224			5.00	
7.00	00700	OPERATION OF PLANT	183	21,102	871,662		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,071	2,643	18,387	8.00	
9.00	00900	HOUSEKEEPING	152	5,737	6,862	0	9.00	
10.00	01000	DIETARY	19	1,546	25,046	74	10.00	
11.00	01100	CAFETERIA	86	4,355	12,106	0	11.00	
13.00	01300	NURSING ADMINISTRATION	240	11,260	9,391	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	68	3,287	17,481	0	14.00	
15.00	01500	PHARMACY	131	7,793	8,908	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	402	38,181	31,535	0	16.00	
17.00	01700	SOCIAL SERVICE	42	1,468	5,261	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	811	26,338	147,567	4,954	15,653	30.00
31.00	03100	INTENSIVE CARE UNIT	178	6,561	22,377	647	2,537	31.00
43.00	04300	NURSERY	67	2,175	1,101	1,145	101	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,178	27,212	109,214	5,516	5,709	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94	3,557	18,057	0	1,751	52.00
53.00	05300	ANESTHESIOLOGY	0	374	7,468	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281	13,014	44,844	1,336	2,030	54.00
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	21,065	29,265	0	888	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	635	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	205	6,762	1,457	0	1,142	65.00
66.00	06600	PHYSICAL THERAPY	202	6,763	16,180	108	507	66.00
69.00	06900	ELECTROCARDIOLOGY	83	3,139	14,016	0	1,142	69.00
69.01	06901	CARDIAC REHAB	66	2,751	23,563	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,702	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,020	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,695	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54	3,802	3,105	0	0	76.00
76.01	03480	ONCOLOGY	154	8,146	56,882	0	2,030	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,379	20,585	68,013	0	1,395	90.00
90.01	09001	WOUND CARE	39	1,253	11,597	0	634	90.01
91.00	09100	EMERGENCY	404	14,771	64,896	4,607	4,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,334	332,120	758,835	18,387	40,644	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	FOUNDATION	0	10	0	0	406	194.00
194.01	07951	MOB	0	41	6,273	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	117	4,618	9,679	0	507	194.04
194.05	07955	PHYSICIANS OFFICE	1,047	36,316	34,216	0	3,045	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	38	5,955	0	0	194.07
194.08	07958	OPS	0	220	32,768	0	1,015	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	41	2,096	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	337	10,235	23,936	37	1,142	194.10
194.11	07960	SPORTS HEALTH	74	2,437	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	33	1,093	0	0	0	194.12
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)	8,983	389,224	871,662	18,387	46,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 10:57 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
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	165,728				10.00
11.00	01100	CAFETERIA	0	83,752			11.00
13.00	01300	NURSING ADMINISTRATION	0	4,216	77,366		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	206	0	118,391	14.00
15.00	01500	PHARMACY	0	1,594	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,506	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	149,742	10,746	30,063	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,986	2,350	6,575	0	31.00
43.00	04300	NURSERY	0	783	2,190	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,516	21,026	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,104	3,088	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,858	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,926	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,619	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	815	0	0	69.00
69.01	06901	CARDIAC REHAB	0	1,220	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	118,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	597	0	0	76.00
76.01	03480	ONCOLOGY	0	1,625	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	13,980	0	0	90.00
90.01	09001	WOUND CARE	0	2,231	0	0	90.01
91.00	09100	EMERGENCY	0	5,156	14,424	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,728	64,072	77,366	118,391	68,132
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	2,839	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	5,377	0	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	223	0	0	194.07
194.08	07958	OPS	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	1,779	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	2,822	0	0	194.10
194.11	07960	SPORTS HEALTH	0	953	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	5,687	0	0	194.12
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	165,728	83,752	77,366	118,391	68,132

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 8/2/2021 10:57 am
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
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	245,590				16.00
17.00	01700	SOCIAL SERVICE	0	37,482			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,018	28,850	1,250,973	0	1,250,973
31.00	03100	INTENSIVE CARE UNIT	3,141	2,844	187,424	0	187,424
43.00	04300	NURSERY	1,983	0	15,659	0	15,659
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,259	139	734,561	0	734,561
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,796	0	130,690	0	130,690
53.00	05300	ANESTHESIOLOGY	2,949	0	52,248	0	52,248
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,644	0	305,607	0	305,607
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	29,180	0	204,888	0	204,888
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,691	0	2,326	0	2,326
65.00	06500	RESPIRATORY THERAPY	9,518	0	29,099	0	29,099
66.00	06600	PHYSICAL THERAPY	5,144	0	121,349	0	121,349
69.00	06900	ELECTROCARDIOLOGY	4,004	0	48,926	0	48,926
69.01	06901	CARDIAC REHAB	600	0	159,013	0	159,013
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	130,093	0	130,093
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	7,020	0	7,020
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	116,827	0	116,827
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	15,030	0	39,824	0	39,824
76.01	03480	ONCOLOGY	15,996	0	155,444	0	155,444
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,055	3,262	209,597	0	209,597
90.01	09001	WOUND CARE	3,624	0	33,371	0	33,371
91.00	09100	EMERGENCY	21,445	2,387	492,419	0	492,419
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,077	37,482	4,427,358	0	4,427,358
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	416	0	416
194.01	07951	MOB	0	0	13,883	0	13,883
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	71,491	0	71,491
194.05	07955	PHYSICIANS OFFICE	8,758	0	212,935	0	212,935
194.06	07956	THE ARBORS	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	13,402	0	13,402
194.08	07958	OPS	0	0	75,233	0	75,233
194.09	07959	MHL ROCHESTER HEALTH CENTER	259	0	4,175	0	4,175
194.10	07961	RHEUMATOLOGY	2,072	0	69,425	0	69,425
194.11	07960	SPORTS HEALTH	0	0	3,464	0	3,464
194.12	07962	BEHAVIORAL HEALTH CLINIC	424	0	7,237	0	7,237
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	245,590	37,482	4,899,019	0	4,899,019

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

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

Worksheet B-1
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
	1.00	1.01	1.02			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	192,560				1.00
1.01 00101	MOB	0	43,769			1.01
1.02 00102	OPS	0	0	27,643		1.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	382	0	0	38,621,063	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,625	4,107	0	3,502,830	-8,011,576
7.00 00700	OPERATION OF PLANT	35,608	266	2,196	783,698	0
8.00 00800	LAUNDRY & LINEN SERVICE	624	0	0	0	0
9.00 00900	HOUSEKEEPING	1,397	142	81	652,789	0
10.00 01000	DIETARY	5,913	0	0	80,909	0
11.00 01100	CAFETERIA	2,858	0	0	367,836	0
13.00 01300	NURSING ADMINISTRATION	2,217	0	0	1,028,944	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	290,813	0
15.00 01500	PHARMACY	2,103	0	0	561,905	0
16.00 01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	1,724,463	0
17.00 01700	SOCIAL SERVICE	1,242	0	0	179,176	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	34,839	0	0	3,479,358	0
31.00 03100	INTENSIVE CARE UNIT	5,283	0	0	764,590	0
43.00 04300	NURSERY	260	0	0	286,690	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	19,487	0	6,297	5,056,947	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,263	0	0	404,211	0
53.00 05300	ANESTHESIOLOGY	1,763	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,206,927	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	4,837	1,345	727	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	344	0	0	880,502	0
66.00 06600	PHYSICAL THERAPY	3,820	0	0	866,453	0
69.00 06900	ELECTROCARDIOLOGY	479	2,830	0	354,445	0
69.01 06901	CARDIAC REHAB	5,563	0	0	283,938	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	2	0
76.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	733	0	0	232,938	0
76.01 03480	ONCOLOGY	0	4,382	9,047	660,100	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	210	15,847	0	5,987,423	0
90.01 09001	WOUND CARE	0	2,738	0	165,914	0
91.00 09100	EMERGENCY	15,321	0	0	1,735,268	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	185,771	31,657	19,907	31,539,069	-8,011,576
NONREIMBURSABLE COST CENTERS						
194.00 07950	FOUNDATION	0	0	0	0	0
194.01 07951	MOB	0	1,481	0	0	0
194.02 07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03 07953	PIH	0	0	0	0	0
194.04 07954	HEALTH COMPANIES	2,285	0	0	502,460	0
194.05 07955	PHYSICIANS OFFICE	4,504	3,574	0	4,494,146	0
194.06 07956	THE ARBORS	0	0	0	0	0
194.07 07957	PAIN MANAGEMENT	0	1,406	0	0	0
194.08 07958	OPS	0	0	7,736	0	0
194.09 07959	MHL ROCHESTER HEALTH CENTER	0	0	0	177,067	0
194.10 07961	RHEUMATOLOGY	0	5,651	0	1,446,951	0
194.11 07960	SPORTS HEALTH	0	0	0	318,862	0
194.12 07962	BEHAVIORAL HEALTH CLINIC	0	0	0	142,508	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	4,528,001	223,692	147,326	11,287,990	
203.00	Unit cost multiplier (Wkst. B, Part I)	23.514754	5.110740	5.329595	0.292275	
204.00	Cost to be allocated (per Wkst. B, Part II)				8,983	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

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

Worksheet B-1
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
	1.00	1.01	1.02			
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000233	5A	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: 15-0072

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	72,797,081				5.00
7.00	00700	OPERATION OF PLANT	3,946,504	205,788			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200,229	624	261,180		8.00
9.00	00900	HOUSEKEEPING	1,072,915	1,620	0	1,843	9.00
10.00	01000	DIETARY	289,050	5,913	1,048	0	4,717
11.00	01100	CAFETERIA	814,474	2,858	0	0	0
13.00	01300	NURSING ADMINISTRATION	2,105,912	2,217	0	5	0
14.00	01400	CENTRAL SERVICES & SUPPLY	614,661	4,127	0	12	0
15.00	01500	PHARMACY	1,457,540	2,103	0	10	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,140,696	7,445	0	15	0
17.00	01700	SOCIAL SERVICE	274,536	1,242	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,925,745	34,839	70,363	617	4,262
31.00	03100	INTENSIVE CARE UNIT	1,227,097	5,283	9,186	100	455
43.00	04300	NURSERY	406,776	260	16,262	4	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,089,287	25,784	78,371	225	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	665,147	4,263	0	69	0
53.00	05300	ANESTHESIOLOGY	69,991	1,763	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,433,811	10,587	18,978	80	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,939,599	6,909	0	35	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,703	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,264,543	344	0	45	0
66.00	06600	PHYSICAL THERAPY	1,264,746	3,820	1,528	20	0
69.00	06900	ELECTROCARDIOLOGY	587,023	3,309	0	45	0
69.01	06901	CARDIAC REHAB	514,430	5,563	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,188,477	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,312,824	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	9,111,284	0	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	711,131	733	0	1	0
76.01	03480	ONCOLOGY	1,523,461	13,429	0	80	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,849,773	16,057	0	55	0
90.01	09001	WOUND CARE	234,343	2,738	0	25	0
91.00	09100	EMERGENCY	2,762,528	15,321	65,444	160	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,117,236	179,151	261,180	1,602	4,717
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	1,947	0	0	16	0
194.01	07951	MOB	7,656	1,481	0	0	0
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	863,575	2,285	0	20	0
194.05	07955	PHYSICIANS OFFICE	6,791,859	8,078	0	120	0
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	7,186	1,406	0	0	0
194.08	07958	OPS	41,230	7,736	0	40	0
194.09	07959	MHL ROCHESTER HEALTH CENTER	392,051	0	0	0	0
194.10	07961	RHEUMATOLOGY	1,914,175	5,651	0	45	0
194.11	07960	SPORTS HEALTH	455,747	0	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	204,419	0	0	0	0
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)	8,011,576	4,380,833	235,549	1,225,481	447,682
203.00		Unit cost multiplier (Wkst. B, Part I)	0.110054	21.288088	0.901865	664.938144	94.908204
204.00		Cost to be allocated (per Wkst. B, Part II)	389,224	871,662	18,387	46,759	165,728
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005347	4.235728	0.070400	25.371134	35.134195

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072			Period: From 01/01/2020 To 12/31/2020		Worksheet B-1 Date/Time Prepared: 8/2/2021 10:57 am	
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)		
		5.00	7.00	8.00	9.00	10.00		
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: 15-0072

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	854,817					11.00
13.00	01300	43,027	282,265				13.00
14.00	01400	2,104	0	100			14.00
15.00	01500	16,267	0	0	100		15.00
16.00	01600	240	0	0	0	165,225,057	16.00
17.00	01700	15,366	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	109,682	109,682	0	0	11,452,518	30.00
31.00	03100	23,989	23,989	0	0	2,113,591	31.00
43.00	04300	7,990	7,990	0	0	1,334,534	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	76,713	76,713	0	0	43,870,243	50.00
52.00	05200	11,266	11,266	0	0	1,881,593	52.00
53.00	05300	0	0	0	0	1,984,215	53.00
54.00	05400	39,372	0	0	0	13,219,370	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	19,636,889	60.00
63.00	06300	0	0	0	0	1,138,175	63.00
65.00	06500	19,657	0	0	0	6,405,088	65.00
66.00	06600	26,730	0	0	0	3,461,599	66.00
69.00	06900	8,315	0	0	0	2,694,814	69.00
69.01	06901	12,448	0	0	0	404,068	69.01
71.00	07100	0	0	100	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	100	0	73.00
76.00	03450	6,094	0	0	0	10,114,698	76.00
76.01	03480	16,586	0	0	0	10,764,757	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	142,716	0	0	0	10,130,986	90.00
90.01	09001	22,775	0	0	0	2,438,916	90.01
91.00	09100	52,625	52,625	0	0	14,431,592	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		653,962	282,265	100	100	157,477,646	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	28,972	0	0	0	0	194.04
194.05	07955	54,883	0	0	0	5,893,472	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	2,275	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	18,159	0	0	0	174,463	194.09
194.10	07961	28,798	0	0	0	1,394,141	194.10
194.11	07960	9,724	0	0	0	0	194.11
194.12	07962	58,044	0	0	0	285,335	194.12
200.00							200.00
201.00							201.00
202.00		964,951	2,436,768	780,517	1,687,729	8,095,293	202.00
203.00		1.128839	8.632909	7,805.170000	16,877.290000	0.048996	203.00
204.00		83,752	77,366	118,391	68,132	245,590	204.00
205.00		0.097977	0.274090	1,183.910000	681.320000	0.001486	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072			Period: From 01/01/2020 To 12/31/2020		Worksheet B-1 Date/Time Prepared: 8/2/2021 10:57 am	
Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	11.00	13.00	14.00	15.00	16.00		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE (HOURS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 MOB		1.01
1.02	00102 OPS		1.02
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
17.00	01700 SOCIAL SERVICE	9,422	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	7,252	30.00
31.00	03100 INTENSIVE CARE UNIT	715	31.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	35	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	06901 CARDIAC REHAB	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	76.00
76.01	03480 ONCOLOGY	0	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	820	90.00
90.01	09001 WOUND CARE	0	90.01
91.00	09100 EMERGENCY	600	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9,422	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 FOUNDATION	0	194.00
194.01	07951 MOB	0	194.01
194.02	07952 NONREIMBURSABLE OTHER	0	194.02
194.03	07953 PIH	0	194.03
194.04	07954 HEALTH COMPANIES	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	194.05
194.06	07956 THE ARBORS	0	194.06
194.07	07957 PAIN MANAGEMENT	0	194.07
194.08	07958 OPS	0	194.08
194.09	07959 MHL ROCHESTER HEALTH CENTER	0	194.09
194.10	07961 RHEUMATOLOGY	0	194.10
194.11	07960 SPORTS HEALTH	0	194.11
194.12	07962 BEHAVIORAL HEALTH CLINIC	0	194.12
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)	348,536	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	36.991722	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	37,482	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.978136	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 8/2/2021 10:57 am
Cost Center Description		SOCIAL SERVICE (HOURS)			
		17.00			
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
				PPS			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	8,987,801		8,987,801	0	8,987,801	30.00
31.00	03100 INTENSIVE CARE UNIT	1,956,753		1,956,753	0	1,956,753	31.00
43.00	04300 NURSERY	617,787		617,787	0	617,787	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	9,318,103		9,318,103	123,954	9,442,057	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,077,148		1,077,148	0	1,077,148	52.00
53.00	05300 ANESTHESIOLOGY	212,444		212,444	0	212,444	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,689,491		3,689,491	0	3,689,491	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	5,505,649		5,505,649	0	5,505,649	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	187,533		187,533	0	187,533	63.00
65.00	06500 RESPIRATORY THERAPY	1,776,970	0	1,776,970	0	1,776,970	65.00
66.00	06600 PHYSICAL THERAPY	1,699,712	0	1,699,712	0	1,699,712	66.00
69.00	06900 ELECTROCARDIOLOGY	893,412		893,412	0	893,412	69.00
69.01	06901 CARDIAC REHAB	723,321		723,321	0	723,321	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,209,845		3,209,845	0	3,209,845	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,457,306		1,457,306	0	1,457,306	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,801,710		11,801,710	0	11,801,710	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,307,457		1,307,457	0	1,307,457	76.00
76.01	03480 ONCOLOGY	2,576,350		2,576,350	0	2,576,350	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	5,339,664		5,339,664	38,634	5,378,298	90.00
90.01	09001 WOUND CARE	480,249		480,249	0	480,249	90.01
91.00	09100 EMERGENCY	4,801,119		4,801,119	0	4,801,119	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,643,856		1,643,856	0	1,643,856	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
200.00	Subtotal (see instructions)	69,263,680	0	69,263,680	162,588	69,426,268	200.00
201.00	Less Observation Beds	1,643,856		1,643,856		1,643,856	201.00
202.00	Total (see instructions)	67,619,824	0	67,619,824	162,588	67,782,412	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

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

Worksheet C
Part I
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		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,433,921		7,433,921		30.00
31.00	03100	INTENSIVE CARE UNIT	965,620		965,620		31.00
43.00	04300	NURSERY	1,329,944		1,329,944		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,304,616	26,517,406	31,822,022	0.292819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,134,832	243,112	2,377,944	0.452975	52.00
53.00	05300	ANESTHESIOLOGY	294,861	1,689,354	1,984,215	0.107067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,056	12,327,626	13,128,682	0.281025	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,060,170	16,576,698	19,636,868	0.280373	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	631,230	749,525	1,380,755	0.135819	63.00
65.00	06500	RESPIRATORY THERAPY	3,585,112	1,630,611	5,215,723	0.340695	65.00
66.00	06600	PHYSICAL THERAPY	317,446	3,138,403	3,455,849	0.491836	66.00
69.00	06900	ELECTROCARDIOLOGY	583,781	3,393,923	3,977,704	0.224605	69.00
69.01	06901	CARDIAC REHAB	47	404,021	404,068	1.790097	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,885,699	6,503,394	8,389,093	0.382621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,341,809	5,642,413	6,984,222	0.208657	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,458,932	44,742,518	52,201,450	0.226080	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	774,939	8,040,111	8,815,050	0.148321	76.00
76.01	03480	ONCOLOGY	32,556	9,783,599	9,816,155	0.262460	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	545,243	596,873	1,142,116	4.675238	90.00
90.01	09001	WOUND CARE	411	2,076,865	2,077,276	0.231192	90.01
91.00	09100	EMERGENCY	1,451,910	12,606,274	14,058,184	0.341518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	413,217	3,228,282	3,641,499	0.451423	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	40,347,352	159,891,008	200,238,360		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	40,347,352	159,891,008	200,238,360		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 10:57 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.296715		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.452975		52.00
53.00	05300 ANESTHESIOLOGY	0.107067		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.281025		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.280373		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.135819		63.00
65.00	06500 RESPIRATORY THERAPY	0.340695		65.00
66.00	06600 PHYSICAL THERAPY	0.491836		66.00
69.00	06900 ELECTROCARDIOLOGY	0.224605		69.00
69.01	06901 CARDIAC REHAB	1.790097		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382621		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.208657		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.226080		73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.148321		76.00
76.01	03480 ONCOLOGY	0.262460		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	4.709065		90.00
90.01	09001 WOUND CARE	0.231192		90.01
91.00	09100 EMERGENCY	0.341518		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.451423		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
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: 15-0072

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

Worksheet C
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		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	8,987,801		8,987,801	0	8,987,801	30.00
31.00	03100 INTENSIVE CARE UNIT	1,956,753		1,956,753	0	1,956,753	31.00
43.00	04300 NURSERY	617,787		617,787	0	617,787	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	9,318,103		9,318,103	123,954	9,442,057	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,077,148		1,077,148	0	1,077,148	52.00
53.00	05300 ANESTHESIOLOGY	212,444		212,444	0	212,444	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,689,491		3,689,491	0	3,689,491	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	5,505,649		5,505,649	0	5,505,649	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	187,533		187,533	0	187,533	63.00
65.00	06500 RESPIRATORY THERAPY	1,776,970	0	1,776,970	0	1,776,970	65.00
66.00	06600 PHYSICAL THERAPY	1,699,712	0	1,699,712	0	1,699,712	66.00
69.00	06900 ELECTROCARDIOLOGY	893,412		893,412	0	893,412	69.00
69.01	06901 CARDIAC REHAB	723,321		723,321	0	723,321	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,209,845		3,209,845	0	3,209,845	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,457,306		1,457,306	0	1,457,306	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,801,710		11,801,710	0	11,801,710	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,307,457		1,307,457	0	1,307,457	76.00
76.01	03480 ONCOLOGY	2,576,350		2,576,350	0	2,576,350	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	5,339,664		5,339,664	38,634	5,378,298	90.00
90.01	09001 WOUND CARE	480,249		480,249	0	480,249	90.01
91.00	09100 EMERGENCY	4,801,119		4,801,119	0	4,801,119	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,643,856		1,643,856	0	1,643,856	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
200.00	Subtotal (see instructions)	69,263,680	0	69,263,680	162,588	69,426,268	200.00
201.00	Less Observation Beds	1,643,856		1,643,856		1,643,856	201.00
202.00	Total (see instructions)	67,619,824	0	67,619,824	162,588	67,782,412	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

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

Worksheet C
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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,433,921		7,433,921		30.00
31.00	03100	INTENSIVE CARE UNIT	965,620		965,620		31.00
43.00	04300	NURSERY	1,329,944		1,329,944		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,304,616	26,517,406	31,822,022	0.292819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,134,832	243,112	2,377,944	0.452975	52.00
53.00	05300	ANESTHESIOLOGY	294,861	1,689,354	1,984,215	0.107067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,056	12,327,626	13,128,682	0.281025	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,060,170	16,576,698	19,636,868	0.280373	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	631,230	749,525	1,380,755	0.135819	63.00
65.00	06500	RESPIRATORY THERAPY	3,585,112	1,630,611	5,215,723	0.340695	65.00
66.00	06600	PHYSICAL THERAPY	317,446	3,138,403	3,455,849	0.491836	66.00
69.00	06900	ELECTROCARDIOLOGY	583,781	3,393,923	3,977,704	0.224605	69.00
69.01	06901	CARDIAC REHAB	47	404,021	404,068	1.790097	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,885,699	6,503,394	8,389,093	0.382621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,341,809	5,642,413	6,984,222	0.208657	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,458,932	44,742,518	52,201,450	0.226080	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	774,939	8,040,111	8,815,050	0.148321	76.00
76.01	03480	ONCOLOGY	32,556	9,783,599	9,816,155	0.262460	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	545,243	596,873	1,142,116	4.675238	90.00
90.01	09001	WOUND CARE	411	2,076,865	2,077,276	0.231192	90.01
91.00	09100	EMERGENCY	1,451,910	12,606,274	14,058,184	0.341518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	413,217	3,228,282	3,641,499	0.451423	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	40,347,352	159,891,008	200,238,360		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	40,347,352	159,891,008	200,238,360		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 10:57 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		76.00
76.01	03480 ONCOLOGY	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
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: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part I Date/Time Prepared: 8/2/2021 10:57 am	
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)	PPS
Title XVIII		Hospital		PPS			
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,250,973	0	1,250,973	5,216	239.83	30.00
31.00	INTENSIVE CARE UNIT	187,424		187,424	455	411.92	31.00
43.00	NURSERY	15,659		15,659	985	15.90	43.00
200.00	Total (Lines 30 through 199)	1,454,056		1,454,056	6,656		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,343	322,092				
31.00	INTENSIVE CARE UNIT	166	68,379				
43.00	NURSERY	0	0				
200.00	Total (Lines 30 through 199)	1,509	390,471				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 8/2/2021 10:57 am
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Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	734,561	31,822,022	0.023083	1,432,669	33,070	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	130,690	2,377,944	0.054959	0	0	52.00
53.00	05300 ANESTHESIOLOGY	52,248	1,984,215	0.026332	70,205	1,849	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	305,607	13,128,682	0.023278	391,585	9,115	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	204,888	19,636,868	0.010434	1,224,120	12,772	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,326	1,380,755	0.001685	162,785	274	63.00
65.00	06500 RESPIRATORY THERAPY	29,099	5,215,723	0.005579	1,620,305	9,040	65.00
66.00	06600 PHYSICAL THERAPY	121,349	3,455,849	0.035114	167,916	5,896	66.00
69.00	06900 ELECTROCARDIOLOGY	48,926	3,977,704	0.012300	272,140	3,347	69.00
69.01	06901 CARDIAC REHAB	159,013	404,068	0.393530	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	130,093	8,389,093	0.015507	670,119	10,392	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	7,020	6,984,222	0.001005	609,102	612	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	116,827	52,201,450	0.002238	2,780,740	6,223	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	39,824	8,815,050	0.004518	388,974	1,757	76.00
76.01	03480 ONCOLOGY	155,444	9,816,155	0.015836	21,548	341	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	209,597	1,142,116	0.183516	5,549	1,018	90.00
90.01	09001 WOUND CARE	33,371	2,077,276	0.016065	0	0	90.01
91.00	09100 EMERGENCY	492,419	14,058,184	0.035027	676,269	23,688	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	228,802	3,641,499	0.062832	27,940	1,756	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	3,202,104	190,508,875		10,521,966	121,150	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Prepared: 8/2/2021 10:57 am
Title XVIII		Hospital	PPS

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	5,216	0.00	1,343	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	455	0.00	166	31.00	
43.00	04300	NURSERY		0	985	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	6,656		1,509	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 10:57 am
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Cost Center Description	Title XVIII					Hospital		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 15-0072

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

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	31,822,022	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,377,944	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,984,215	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,128,682	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	19,636,868	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,380,755	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,215,723	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,455,849	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,977,704	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	404,068	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,389,093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,984,222	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	52,201,450	0.000000	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	8,815,050	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	9,816,155	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,142,116	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	2,077,276	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	14,058,184	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,641,499	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	190,508,875		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 10:57 am
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Cost Center Description		Title XVIII				Hospital	
		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)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	1,432,669	0	4,633,322	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	70,205	0	284,515	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	391,585	0	2,704,578	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,224,120	0	1,856,046	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	162,785	0	83,552	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,620,305	0	395,373	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	167,916	0	10,098	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	272,140	0	968,685	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	165,647	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	670,119	0	725,930	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	609,102	0	1,270,564	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,780,740	0	11,825,369	0	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	388,974	0	2,432,229	0	76.00
76.01	03480 ONCOLOGY	0.000000	21,548	0	3,282,948	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	5,549	0	447,157	0	90.00
90.01	09001 WOUND CARE	0.000000	0	0	678,465	0	90.01
91.00	09100 EMERGENCY	0.000000	676,269	0	2,387,546	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	27,940	0	657,573	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		10,521,966	0	34,809,597	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 10:57 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.292819	4,633,322	0	0	1,356,725	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.452975	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.107067	284,515	0	0	30,462	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.281025	2,704,578	0	0	760,054	54.00	
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00 06000 LABORATORY	0.280373	1,856,046	0	0	520,385	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.135819	83,552	0	0	11,348	63.00	
65.00 06500 RESPIRATORY THERAPY	0.340695	395,373	0	0	134,702	65.00	
66.00 06600 PHYSICAL THERAPY	0.491836	10,098	0	0	4,967	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.224605	968,685	0	0	217,571	69.00	
69.01 06901 CARDIAC REHAB	1.790097	165,647	0	0	296,524	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382621	725,930	0	0	277,756	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.208657	1,270,564	0	0	265,112	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.226080	11,825,369	0	56,287	2,673,479	73.00	
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.148321	2,432,229	0	0	360,751	76.00	
76.01 03480 ONCOLOGY	0.262460	3,282,948	0	0	861,643	76.01	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	4.675238	447,157	0	0	2,090,565	90.00	
90.01 09001 WOUND CARE	0.231192	678,465	0	0	156,856	90.01	
91.00 09100 EMERGENCY	0.341518	2,387,546	0	35	815,390	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.451423	657,573	0	0	296,844	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0.000000		0	0		95.00	
200.00	Subtotal (see instructions)		34,809,597	0	56,322	11,131,134	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		34,809,597	0	56,322	11,131,134	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 10:57 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
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	12,725		73.00
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		76.00
76.01 03480 ONCOLOGY	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CARE	0	0		90.01
91.00 09100 EMERGENCY	0	12		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	12,737		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	12,737		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 10:57 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,216	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,216	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,262	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,343	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)		8,987,801	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)		8,987,801	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)		8,987,801	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)		1,723.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,314,150	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)		2,314,150	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 10:57 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,956,753	455	4,300.56	166	713,893	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)					2,948,931	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,976,974	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)					390,471	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					121,150	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					511,621	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,465,353	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)					954	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,723.12	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,643,856	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 10:57 am	
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	1,250,973	8,987,801	0.139186	1,643,856	228,802	90.00
91.00	Nursing School cost	0	8,987,801	0.000000	1,643,856	0	91.00
92.00	Allied health cost	0	8,987,801	0.000000	1,643,856	0	92.00
93.00	All other Medical Education	0	8,987,801	0.000000	1,643,856	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 10:57 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,216 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,216 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4,262 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)			322 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)			985 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)			8,987,801 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)			8,987,801 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)			8,987,801 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)			1,723.12 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			554,845 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)			554,845 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1	
		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)	617,787	985	627.19	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,956,753	455	4,300.56	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)					582,989	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,137,834	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)					954	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,723.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,643,856	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 10:57 am	
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	1,250,973	8,987,801	0.139186	1,643,856	228,802	90.00
91.00	Nursing School cost	0	8,987,801	0.000000	1,643,856	0	91.00
92.00	Allied health cost	0	8,987,801	0.000000	1,643,856	0	92.00
93.00	All other Medical Education	0	8,987,801	0.000000	1,643,856	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 10:57 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,155,360		30.00
31.00	03100 INTENSIVE CARE UNIT		339,271		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.296715	1,432,669	425,094	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.452975	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.107067	70,205	7,517	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.281025	391,585	110,045	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.280373	1,224,120	343,210	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.135819	162,785	22,109	63.00
65.00	06500 RESPIRATORY THERAPY	0.340695	1,620,305	552,030	65.00
66.00	06600 PHYSICAL THERAPY	0.491836	167,916	82,587	66.00
69.00	06900 ELECTROCARDIOLOGY	0.224605	272,140	61,124	69.00
69.01	06901 CARDIAC REHAB	1.790097	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382621	670,119	256,402	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.208657	609,102	127,093	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.226080	2,780,740	628,670	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.148321	388,974	57,693	76.00
76.01	03480 ONCOLOGY	0.262460	21,548	5,655	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	4.709065	5,549	26,131	90.00
90.01	09001 WOUND CARE	0.231192	0	0	90.01
91.00	09100 EMERGENCY	0.341518	676,269	230,958	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.451423	27,940	12,613	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,521,966	2,948,931	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)		10,521,966		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 10:57 am	
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		430,665		30.00
31.00	03100 INTENSIVE CARE UNIT		26,480		31.00
43.00	04300 NURSERY		147,276		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.292819	281,050	82,297	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.452975	41,678	18,879	52.00
53.00	05300 ANESTHESIOLOGY	0.107067	16,923	1,812	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.281025	21,793	6,124	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.280373	132,079	37,031	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.135819	20,006	2,717	63.00
65.00	06500 RESPIRATORY THERAPY	0.340695	92,803	31,618	65.00
66.00	06600 PHYSICAL THERAPY	0.491836	4,053	1,993	66.00
69.00	06900 ELECTROCARDIOLOGY	0.224605	4,301	966	69.00
69.01	06901 CARDIAC REHAB	1.790097	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382621	102,695	39,293	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.208657	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.226080	241,041	54,495	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.148321	16,536	2,453	76.00
76.01	03480 ONCOLOGY	0.262460	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	4.675238	60,602	283,329	90.00
90.01	09001 WOUND CARE	0.231192	0	0	90.01
91.00	09100 EMERGENCY	0.341518	47,685	16,285	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.451423	8,190	3,697	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,091,435	582,989	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,091,435		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072 Component CCN: 15-U072	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 10:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CARE	0.000000	0	90.01
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 10:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,245,682	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,076,393	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)		25,070	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		22,491	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)		39.39	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)		4.58	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.04	31.00
32.00	Sum of lines 30 and 31		23.62	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		99,663	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 10:57 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)		0.000097346	0.000104522	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		812,897	866,489	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		608,562	218,403	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		826,965		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,296,264		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		5,120,917		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			5,120,917	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			262,552	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			104,193	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			5,487,662	59.00
60.00	Primary payer payments			28,215	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,459,447	61.00
62.00	Deductibles billed to program beneficiaries			492,712	62.00
63.00	Coinurance billed to program beneficiaries			1,760	63.00
64.00	Allowable bad debts (see instructions)			47,479	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			30,861	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			47,479	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,995,836	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-248	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 10:57 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	591,567	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	298,521	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		42,434	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,843,242	71.00
71.01	Sequestration adjustment (see instructions)		38,565	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		5,870,198	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-65,521	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		173,947	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0072

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/2/2021 10:57 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,245,682	0	2,245,682		2,245,682	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,076,393	0		1,076,393	1,076,393	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	25,070	0	25,070		25,070	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	22,491	0		22,491	22,491	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	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	99,663	0	67,371	32,292	99,663	11.00
11.01	Uncompensated care payments	36.00	826,965	0	608,562	218,403	826,965	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	4,296,264	0	2,946,685	1,349,579	4,296,264	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,120,917	0	3,467,158	1,653,759	5,120,917	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,120,917	0	3,467,158	1,653,759	5,120,917	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0072

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/2/2021 10:57 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	262,552	0	180,056	82,496	262,552	16.00
17.00	Special add-on payments for new technologies	54.00	104,193	0	0	104,193	104,193	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,647,214	1,840,448	5,487,662	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	250,417	0	174,528	75,889	250,417	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	12,135	0	5,528	6,607	12,135	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	262,552	0	180,056	82,496	262,552	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				0.162197	0.162200		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			591,567		591,567	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				298,521	298,521	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: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 10:57 am
Title XVIII			Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
	0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,245,682	2,245,682		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,076,393		1,076,393	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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		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	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	25,070	25,070		2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	22,491		22,491	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00
4.00	Managed care simulated payments	3.00	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	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	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	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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	9.01
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	99,663	67,371	32,292	11.00
11.01	Uncompensated care payments	36.00	826,965	608,562	218,403	11.01
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,296,264	2,946,685	1,349,579	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,120,917	3,467,158	1,653,759	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,120,917	3,467,158	1,653,759	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	262,552	180,056	82,496	16.00
17.00	Special add-on payments for new technologies	54.00	104,193	0	104,193	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	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00
19.00	SUBTOTAL			3,647,214	1,840,448	5,487,662

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 10:57 am
		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	250,417	174,528	75,889	250,417	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	12,135	5,528	6,607	12,135	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	262,552	180,056	82,496	262,552	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	591,567	591,567		591,567	27.00
28.00	Low volume adjustment prior to October 1	70.96	591,567	591,567		591,567	28.00
29.00	Low volume adjustment on or after October 1	70.97	298,521		298,521	298,521	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-248	4,597	-4,845	-248	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	0	0	0	0	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		42,434		42,434	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 10:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,737	1.00
2.00	Medical and other services reimbursed under OPSS (see instructions)		11,131,134	2.00
3.00	OPSS payments		9,273,670	3.00
4.00	Outlier payment (see instructions)		87,617	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)		12,737	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		56,322	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)		56,322	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		56,322	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		43,585	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)		12,737	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)		9,361,287	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)		1,915,609	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)		7,458,415	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)		7,458,415	30.00
31.00	Primary payer payments		1,866	31.00
32.00	Subtotal (line 30 minus line 31)		7,456,549	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)		137,056	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		89,086	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		137,056	36.00
37.00	Subtotal (see instructions)		7,545,635	37.00
38.00	MSP-LCC reconciliation amount from PS&R		105	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		7,545,530	40.00
40.01	Sequestration adjustment (see instructions)		49,800	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		7,485,768	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		9,962	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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: 15-0072		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 8/2/2021 10:57 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,808,498		7,405,538	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	61,700	12/31/2020	80,230	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)		61,700		80,230	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)		5,870,198		7,485,768	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		0		9,962	6.01	
6.02	SETTLEMENT TO PROGRAM		65,521		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,804,677		7,495,730	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: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 10:57 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & 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 - SWING BEDS		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2
		Component CCN: 15-U072	Date/Time Prepared: 8/2/2021 10:57 am	
		Title XIX	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 10:57 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,137,834		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,137,834	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,137,834	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		647,948		8.00
9.00	Ancillary service charges		1,091,435	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,739,383	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,739,383	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		601,549	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,137,834	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,137,834	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,137,834	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,137,834	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,137,834	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,137,834	0	40.00
41.00	Interim payments		854,482	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		283,352	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: 15-0072

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

Worksheet G

Date/Time Prepared:
8/2/2021 10:57 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	29,305,668	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	80,505,236	0	0	0	4.00
5.00	Other receivable	3,414,889	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-58,707,580	0	0	0	6.00
7.00	Inventory	1,748,984	0	0	0	7.00
8.00	Prepaid expenses	1,087,342	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	57,354,539	0	0	0	11.00
FIXED ASSETS						
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	838,517	0	0	0	13.00
14.00	Accumulated depreciation	-482,630	0	0	0	14.00
15.00	Buildings	65,043,987	0	0	0	15.00
16.00	Accumulated depreciation	-40,627,644	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,611,191	0	0	0	19.00
20.00	Accumulated depreciation	-4,035,485	0	0	0	20.00
21.00	Automobiles and trucks	108,602	0	0	0	21.00
22.00	Accumulated depreciation	-105,908	0	0	0	22.00
23.00	Major movable equipment	48,764,305	0	0	0	23.00
24.00	Accumulated depreciation	-26,159,224	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)	51,161,494	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,393,369	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	13,185,386	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,578,755	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	125,094,788	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	14,360,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,820,455	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,971,687	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,383,836	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,536,830	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	33,224,843	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,224,843	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,761,673	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	72,333,115				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)	72,333,115	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	125,094,788	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0072

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

Worksheet G-1

Date/Time Prepared:
8/2/2021 10:57 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		72,687,109		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-353,994				2.00
3.00	Total (sum of line 1 and line 2)		72,333,115		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)		72,333,115		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		72,333,115		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0072

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/2/2021 10:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	8,575,239		8,575,239	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)	8,575,239		8,575,239	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,030,632		1,030,632	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)	1,030,632		1,030,632	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,605,871		9,605,871	17.00
18.00	Ancillary services	28,058,742	135,127,081	163,185,823	18.00
19.00	Outpatient services	2,188,170	25,608,659	27,796,829	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	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	NONREIMBURSABLE	8,264	8,556,812	8,565,076	27.00
27.01	PRO FEES	455,897	15,523,499	15,979,396	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,316,944	184,816,051	225,132,995	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		99,008,369		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)		99,008,369		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 8/2/2021 10:57 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	225,132,995	1.00
2.00	Less contractual allowances and discounts on patients' accounts	142,095,348	2.00
3.00	Net patient revenues (line 1 minus line 2)	83,037,647	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	99,008,369	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,970,722	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,720,755	24.00
24.01	INVESTMENT INCOME	539,608	24.01
24.50	COVID-19 PHE Funding	13,356,365	24.50
25.00	Total other income (sum of lines 6-24)	15,616,728	25.00
26.00	Total (line 5 plus line 25)	-353,994	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-353,994	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0072	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 10:57 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		250,417	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,135	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)		13.75	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)		262,552	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