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: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 6/11/2021 9:17 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/11/2021 Time: 9:17 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SULLIVAN COUNTY COMMUNITY HOSPITAL (15-1327) 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)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	375,014	-77,635	0	0	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	148,809	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		6,865		0	10.00
200.00	Total	0	523,823	-70,770	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 9:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2200 NORTH SECTION STREET	PO Box: 10			1.00
2.00	City: SULLIVAN	State: IN	Zip Code: 47882-	County: SULLIVAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	N	O	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	15Z327	45460		06/01/2005	N	O	N	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	FAMILY PRACTICE ASSOCIATES	158540	45460		10/01/2019	N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 9:17 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 9:17 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 9:17 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 9:17 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	212,632	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 9:17 am

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 9:17 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 6/11/2021 9:17 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/13/2021	Y	04/13/2021	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)	Y	04/13/2021	Y	04/13/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 6/11/2021 9:17 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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.	Y	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-4000	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 6/11/2021 9:17 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/11/2021 9:17 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	47,350.00	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)		21	7,686	47,350.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	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)		25	9,150	47,350.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/11/2021 9:17 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,014	53	1,894			1.00
2.00	HMO and other (see instructions)	0	62				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	297	0	349			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)	1,311	53	2,243			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		12	206			13.00
14.00	Total (see instructions)	1,311	65	2,449	0.00	331.67	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	0	0	0	0.00	0.00	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	2,235	0	12,839	0.00	11.35	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	343.02	27.00
28.00	Observation Bed Days		43	1,170			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			22			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	17			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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/11/2021 9:17 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	268	9	561	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	268	9	561	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/11/2021 9:17 am

RHC I

				1.00		
	Clinic Address and Identification					
1.00	Street			2229 MARY SHERMAN DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SULLIVAN		IN	47882	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SULLIVAN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	05:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/11/2021 9:17 am

RHC I

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 6/11/2021 9:17 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.314382	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,925,197	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	764,242	5.00
6.00	Medicaid charges	13,630,182	6.00
7.00	Medicaid cost (line 1 times line 6)	4,285,084	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)	0	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)	886,952	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	11,417,562	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	3,589,476	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)	2,702,524	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)	2,702,524	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)	93,856	848,124	941,980	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	29,507	848,124	877,631	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,535	7,917	9,452	22.00
23.00	Cost of charity care (line 21 minus line 22)	27,972	840,207	868,179	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)	2,468,487	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	661,803	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,018,158	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,450,329	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	812,312	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,680,491	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,383,015	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		613,989	613,989	183,404	797,393	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,211,413	1,211,413	21,522	1,232,935	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	155,676	5,788,854	5,944,530	0	5,944,530	4.00
5.01	00590	IS/ACCOUNTING/MARKETING	619,400	686,490	1,305,890	0	1,305,890	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	730,529	1,425,236	2,155,765	0	2,155,765	5.02
5.03	00592	OTHER A&G	671,701	1,345,237	2,016,938	383,609	2,400,547	5.03
7.00	00700	OPERATION OF PLANT	428,870	770,915	1,199,785	84,460	1,284,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,002	34,509	84,511	0	84,511	8.00
9.00	00900	HOUSEKEEPING	344,070	94,630	438,700	0	438,700	9.00
10.00	01000	DIETARY	359,035	239,674	598,709	0	598,709	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	357,874	46,631	404,505	0	404,505	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,806	-58,753	76,053	0	76,053	14.00
15.00	01500	PHARMACY	400,167	1,274,367	1,674,534	-339	1,674,195	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	340,634	24,902	365,536	0	365,536	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	633,650	633,650	0	633,650	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,708,289	145,744	2,854,033	174,152	3,028,185	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,575	14,575	-14,575	0	31.00
43.00	04300	NURSERY	0	0	0	96,543	96,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,212,461	663,688	1,876,149	-852,667	1,023,482	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	693,439	127,226	820,665	-770,192	50,473	52.00
53.00	05300	ANESTHESIOLOGY	0	8,813	8,813	-8,570	243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,457	369,089	941,546	-28,784	912,762	54.00
54.01	05401	ULTRASOUND	142,940	33,703	176,643	-4,581	172,062	54.01
56.00	05600	RADIOISOTOPE	0	149,233	149,233	-38,593	110,640	56.00
60.00	06000	LABORATORY	821,461	1,608,891	2,430,352	-34,202	2,396,150	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	10,261	10,261	-10,261	0	64.00
65.00	06500	RESPIRATORY THERAPY	467,959	108,989	576,948	-31,804	545,144	65.00
66.00	06600	PHYSICAL THERAPY	688,297	39,150	727,447	-8,369	719,078	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,660	4,913	172,573	-78	172,495	67.00
68.00	06800	SPEECH PATHOLOGY	75,781	841	76,622	0	76,622	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,730	2,730	0	2,730	70.00
70.01	07001	CARDIOPULMONARY	52,489	1,921	54,410	-101	54,309	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	113,854	113,854	548,551	662,405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	131,458	131,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	960,921	541,284	1,502,205	-102,564	1,399,641	88.00
90.00	09000	CLINIC	3,438	162,703	166,141	-25,111	141,030	90.00
90.01	09001	JV CLINIC	579,135	49,306	628,441	-23,189	605,252	90.01
90.02	09002	CLINIC - LAKESIDE	9,504	8,642	18,146	-8,642	9,504	90.02
90.03	09003	CLINIC - QUICKCARE	84,934	0	84,934	0	84,934	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	0	496,276	496,276	90.04
90.05	09005	ORTHO CLINIC	0	0	0	189,576	189,576	90.05
91.00	09100	EMERGENCY	820,378	1,341,245	2,161,623	-7,434	2,154,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	121,065	339,521	460,586	-114,640	345,946	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,775,372	19,978,066	34,753,438	224,855	34,978,293	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	189,887	189,887	-174,811	15,076	192.00
192.01	19201	MSO CLINICS	5,087	0	5,087	0	5,087	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	16,064	1,199	17,263	0	17,263	194.01
194.02	07952	MARKETING	114,802	125,907	240,709	-113,396	127,313	194.02
194.03	07953	NONREIMBURSABLE - OTHER	23,498	-834	22,664	63,493	86,157	194.03
194.04	07954	TH PAIN	23	20,076	20,099	-141	19,958	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	14,934,846	20,314,301	35,249,147	0	35,249,147	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/11/2021 9:17 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	-96,804	700,589		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,447	1,236,382		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,795,688	4,148,842		4.00
5.01	00590	IS/ACCOUNTING/MARKETING	-22,903	1,282,987		5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	-1,066,104	1,089,661		5.02
5.03	00592	OTHER A&G	264,966	2,665,513		5.03
7.00	00700	OPERATION OF PLANT	-6,801	1,277,444		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,511		8.00
9.00	00900	HOUSEKEEPING	0	438,700		9.00
10.00	01000	DIETARY	-112,789	485,920		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-5,924	398,581		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-918	75,135		14.00
15.00	01500	PHARMACY	-349,395	1,324,800		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,373	362,163		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-633,650	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-187,736	2,840,449		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	96,543		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-117,026	906,456		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,473		52.00
53.00	05300	ANESTHESIOLOGY	0	243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,000	911,762		54.00
54.01	05401	ULTRASOUND	0	172,062		54.01
56.00	05600	RADIOISOTOPE	0	110,640		56.00
60.00	06000	LABORATORY	0	2,396,150		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	545,144		65.00
66.00	06600	PHYSICAL THERAPY	0	719,078		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	172,495		67.00
68.00	06800	SPEECH PATHOLOGY	0	76,622		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,730		70.00
70.01	07001	CARDIOPULMONARY	0	54,309		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,898	817,303		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	131,458		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-569	1,399,072		88.00
90.00	09000	CLINIC	0	141,030		90.00
90.01	09001	JV CLINIC	46,684	651,936		90.01
90.02	09002	CLINIC - LAKESIDE	385,097	394,601		90.02
90.03	09003	CLINIC - QUICKCARE	122,139	207,073		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	-392,202	104,074		90.04
90.05	09005	ORTHO CLINIC	-116,009	73,567		90.05
91.00	09100	EMERGENCY	0	2,154,189		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	BEHAVIOR HEALTH	-12,179	333,767		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,943,839	31,034,454		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,076		192.00
192.01	19201	MSO CLINICS	0	5,087		192.01
192.03	19203	FPA	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0		194.00
194.01	07951	WELLNESS CLINIC	0	17,263		194.01
194.02	07952	MARKETING	0	127,313		194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	86,157		194.03
194.04	07954	TH PAIN	-224	19,734		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,944,063	31,305,084		200.00

RECLASSIFICATIONS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/11/2021 9:17 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - ADVERTISING RECLASS					
1.00	OTHER A&G	5.03	0	113,396		1.00
	0		0	113,396		
	B - DELIVERY ROOM RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	602,525	62,311		1.00
2.00	NURSERY	43.00	62,523	34,020		2.00
	0		665,048	96,331		
	C - OXYGEN RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	34,879		1.00
	0		0	34,879		
	D - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	513,672		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	131,458		2.00
3.00	RESPIRATORY THERAPY	65.00	0	3,075		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	648,205		
	E - BEHAVIOR HEALTH OVERHEAD					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	84,824		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	21,522		2.00
3.00	OPERATION OF PLANT	7.00	0	8,148		3.00
	0		0	114,494		
	F - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	81		1.00
	0		0	81		
	G - PRIVATE PHYSICIAN RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	98,580		1.00
2.00	OPERATION OF PLANT	7.00	0	76,231		2.00
	0		0	174,811		
	H - ICU RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	14,575		1.00
	0		0	14,575		
	I - WOMEN'S HEALTH RECLASS					
1.00	WOMEN'S HEALTH CLINIC	90.04	444,519	55,917		1.00
	TOTALS		444,519	55,917		
	J - ORTHO CLINIC RECLASS					
1.00	ORTHO CLINIC	90.05	170,235	20,974		1.00
	TOTALS		170,235	20,974		
	K - IV RECLASS					
1.00	OPERATING ROOM	50.00	0	1,579		1.00
	TOTALS		0	1,579		
	L - CARE COORDINATION RECLASS					
1.00	OTHER A&G	5.03	171,547	98,666		1.00
2.00	NONREIMBURSABLE - OTHER	194.03	63,493	0		2.00
	TOTALS		235,040	98,666		
500.00	Grand Total: Increases		1,514,842	1,373,908		500.00

RECLASSIFICATIONS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/11/2021 9:17 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - ADVERTISING RECLASS					
1.00	MARKETING	194.02	0	113,396	0	1.00
	0		0	113,396		
	B - DELIVERY ROOM RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	665,048	96,331	0	1.00
2.00		0.00	0	0	0	2.00
	0		665,048	96,331		
	C - OXYGEN RECLASS					
1.00	RESPIRATORY THERAPY	65.00	0	34,879	0	1.00
	0		0	34,879		
	D - MEDICAL SUPPLIES RECLASS					
1.00	PHARMACY	15.00	0	339	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,823	0	2.00
3.00	OPERATING ROOM	50.00	0	329,331	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	8,813	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	8,570	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	28,784	0	6.00
7.00	ULTRASOUND	54.01	0	4,581	0	7.00
8.00	RADIOISOTOPE	56.00	0	38,593	0	8.00
9.00	LABORATORY	60.00	0	34,202	0	9.00
10.00	INTRAVENOUS THERAPY	64.00	0	8,682	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	8,369	0	11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	78	0	12.00
13.00	CARDIOPULMONARY	70.01	0	101	0	13.00
14.00	RURAL HEALTH CLINIC	88.00	0	102,483	0	14.00
15.00	CLINIC	90.00	0	25,111	0	15.00
16.00	JV CLINIC	90.01	0	23,189	0	16.00
17.00	CLINIC - LAKESIDE	90.02	0	8,642	0	17.00
18.00	EMERGENCY	91.00	0	7,434	0	18.00
19.00	BEHAVIOR HEALTH	93.00	0	146	0	19.00
20.00	TH PAIN	194.04	0	141	0	20.00
21.00	WOMEN'S HEALTH CLINIC	90.04	0	4,160	0	21.00
22.00	ORTHO CLINIC	90.05	0	1,633	0	22.00
	0		0	648,205		
	E - BEHAVIOR HEALTH OVERHEAD					
1.00	BEHAVIOR HEALTH	93.00	0	114,494	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	0	3.00
	0		0	114,494		
	F - UTILITIES RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	0	81	0	1.00
	0		0	81		
	G - PRIVATE PHYSICIAN RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	174,811	9	1.00
2.00		0.00	0	0	0	2.00
	0		0	174,811		
	H - ICU RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	0	14,575	0	1.00
	0		0	14,575		
	I - WOMEN'S HEALTH RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	444,519	55,917	0	1.00
	TOTALS		444,519	55,917		
	J - ORTHO CLINIC RECLASS					
1.00	OPERATING ROOM	50.00	170,235	20,974	0	1.00
	TOTALS		170,235	20,974		
	K - IV RECLASS					
1.00	INTRAVENOUS THERAPY	64.00	0	1,579	0	1.00
	TOTALS		0	1,579		
	L - CARE COORDINATION RECLASS					
1.00	OPERATING ROOM	50.00	235,040	98,666	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		235,040	98,666		
500.00	Grand Total: Decreases		1,514,842	1,373,908		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 6/11/2021 9:17 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,002,127	34,000	0	34,000	0	1.00
2.00	Land Improvements	3,096,707	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,935,331	1,661,016	0	1,661,016	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,611,722	14,922	0	14,922	0	5.00
6.00	Movable Equipment	20,920,722	0	0	0	128,253	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,566,609	1,709,938	0	1,709,938	128,253	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,566,609	1,709,938	0	1,709,938	128,253	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,036,127	0	1.00
2.00	Land Improvements	3,096,707	0	2.00
3.00	Buildings and Fixtures	16,596,347	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	6,626,644	0	5.00
6.00	Movable Equipment	20,792,469	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	48,148,294	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	48,148,294	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 6/11/2021 9:17 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	469,526	0	144,463	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,124,299	87,114	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,593,825	87,114	144,463	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	613,989		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,211,413		2.00
3.00	Total (sum of lines 1-2)	0	1,825,402		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 6/11/2021 9:17 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	27,355,825	0	27,355,825	0.568158	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	20,792,469	0	20,792,469	0.431842	0	2.00
3.00	Total (sum of lines 1-2)	48,148,294	0	48,148,294	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	695,882	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,149,580	87,114	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,845,462	87,114	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,707	0	0	0	700,589	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-312	0	0	0	1,236,382	2.00
3.00	Total (sum of lines 1-2)	4,395	0	0	0	1,936,971	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/11/2021 9:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-144,463	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,179	OTHER A&G	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,882	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,291,761			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	1,588,762			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-112,789	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-551	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-6,113	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,373	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/11/2021 9:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	A&G - ADVERTISING	A	-108,946	OTHER A&G	5.03	0	33.00
33.01	PAIN MGMT ADVERTISING	A	-1,261	JV CLINIC	90.01	0	33.01
33.02	BEHAVIORAL HEALTH ADVERTISING	A	-1,665	BEHAVIOR HEALTH	93.00	0	33.02
33.03	ORTHO ADVERTISING	A	-3,695	OPERATING ROOM	50.00	0	33.03
33.04	TH PAIN ADVERTISING	A	-224	TH PAIN	194.04	0	33.04
33.05	PHYSICIAN RECRUITMENT	A	-121,763	OTHER A&G	5.03	0	33.05
33.06	FLOWERS & PLANTS	A	-1,524	OTHER A&G	5.03	0	33.06
33.07	SURETY BONDS	A	-585	OTHER A&G	5.03	0	33.07
33.08	SURETY BONDS	A	-379	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	LOBBYING EXPENSES	A	-2,262	OTHER A&G	5.03	0	33.09
33.10	DOMESTIC HEALTHCARE CLAIMS	B	-1,640,322	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MISC INCOME	B	-9,363	OTHER A&G	5.03	0	33.11
33.12	MISC INCOME	B	-1,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MISC EDUCATION REVENUE	B	-5,924	NURSING ADMINISTRATION	13.00	0	33.13
33.14	340B REVENUE	A	-343,282	PHARMACY	15.00	0	33.14
33.15	BOND ISSUANCE COST	A	4,707	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.15
33.16	BEHAVIORAL HEALTH - START-UP COSTS	A	5,581	BEHAVIOR HEALTH	93.00	0	33.16
33.17	BEHAVIORAL HEALTH - START-UP COSTS	A	589	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	HOSPITAL ASSESSMENT FEE	B	-1,064,058	BUSINESS OFFICE & ADMITTING	5.02	0	33.18
33.19	CRNA EXPENSES	A	-633,650	NONPHYSICIAN ANESTHETISTS	19.00	0	33.19
33.20	FPA ADVERTISING EXPENSE	A	-1,270	RURAL HEALTH CLINIC	88.00	0	33.20
33.21	INTEREST INCOME - PT ACCT	B	-2,046	BUSINESS OFFICE & ADMITTING	5.02	0	33.21
33.22	PHYSICIAN BENEFITS	A	-32,372	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,944,063				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 6/11/2021 9:17 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	90.01	JV CLINIC	JV PAIN MANAGEMENT CLINIC	0	99,967	1.00
2.00	90.01	JV CLINIC	JV PAIN MANAGEMENT CLINIC	0	6,828	2.00
3.00	90.01	JV CLINIC	JV PAIN MANAGEMENT CLINIC	621,128	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	JV PAIN MANAGEMENT CLINIC	79,984	0	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	FITNESS CENTER - PROP INSURA	0	312	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	FITNESS CENTER - HR	0	3,866	4.02
4.03	5.01	IS/ACCOUNTING/MARKETING	FITNESS CENTER - FISCAL ACCT	0	4,218	4.03
4.04	5.03	OTHER A&G	FITNESS CENTER - ADMIN	0	4,403	4.04
4.05	7.00	OPERATION OF PLANT	FITNESS CENTER - MAINT	0	2,919	4.05
4.06	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS M	0	918	4.06
4.07	1.00	NEW CAP REL COSTS-BLDG & FIX	LAKESIDE DEPRECIATION	42,952	0	4.07
4.08	2.00	NEW CAP REL COSTS-MVBLE EQUI	LAKESIDE DEPRECIATION	3,759	0	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	LAKSIDE BENEFITS	2,449	0	4.09
4.10	5.03	OTHER A&G	LAKESIDE ADMIN	388,406	0	4.10
4.11	71.00	MEDICAL SUPPLIES CHARGED TO	LAKESIDE BILLABLE SUPPLIES	143,782	0	4.11
4.12	90.02	CLINIC - LAKESIDE	LAKESIDE SALARIES & WAGES	226,328	0	4.12
4.13	90.02	CLINIC - LAKESIDE	LAKESIDE OTHER EXPENSE	158,769	0	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	QUICKCARE BENEFITS	540	0	4.14
4.15	5.03	OTHER A&G	QUICKCARE ADMIN	148,069	0	4.15
4.16	71.00	MEDICAL SUPPLIES CHARGED TO	QUICKCARE BILLABLE SUPPLIES	11,667	0	4.16
4.17	90.03	CLINIC - QUICKCARE	QUICKCARE SALARIES & WAGES	67,528	0	4.17
4.18	90.03	CLINIC - QUICKCARE	QUICKCARE OTHER EXPENSE	54,611	0	4.18
4.19	88.00	RURAL HEALTH CLINIC	FPA OTHER EXPENSE	701	0	4.19
4.20	5.01	IS/ACCOUNTING/MARKETING	MSO IS/ACCOUNTING/MARKETING	0	18,685	4.20
4.21	5.03	OTHER A&G	MSO OTHER ADMIN	0	17,484	4.21
4.22	4.00	EMPLOYEE BENEFITS DEPARTMENT	MSO EMPLOYEE BENEFITS	0	202,311	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
4.25	0.00			0	0	4.25
4.26	0.00			0	0	4.26
4.27	0.00			0	0	4.27
4.28	0.00			0	0	4.28
4.29	0.00			0	0	4.29
4.30	0.00			0	0	4.30
4.31	0.00			0	0	4.31
4.32	0.00			0	0	4.32
4.33	0.00			0	0	4.33
5.00	0		0	1,950,673	361,911	5.00

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 6/11/2021 9:17 am

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 6/11/2021 9:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-99,967	0		1.00
2.00	-6,828	0		2.00
3.00	621,128	0		3.00
4.00	79,984	0		4.00
4.01	-312	11		4.01
4.02	-3,866	0		4.02
4.03	-4,218	0		4.03
4.04	-4,403	0		4.04
4.05	-2,919	0		4.05
4.06	-918	0		4.06
4.07	42,952	9		4.07
4.08	3,759	9		4.08
4.09	2,449	0		4.09
4.10	388,406	0		4.10
4.11	143,782	0		4.11
4.12	226,328	0		4.12
4.13	158,769	0		4.13
4.14	540	0		4.14
4.15	148,069	0		4.15
4.16	11,667	0		4.16
4.17	67,528	0		4.17
4.18	54,611	0		4.18
4.19	701	0		4.19
4.20	-18,685	9		4.20
4.21	-17,484	0		4.21
4.22	-202,311	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
4.32	0	0		4.32
4.33	0	0		4.33
5.00	1,588,762			5.00

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

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

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

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

6.00	JV PAIN CLINIC		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 6/11/2021 9:17 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 6/11/2021 9:17 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	30.00	ADULTS & PEDIATRICS	187,736	187,736	0	0	0	1.00
2.00	50.00	OPERATING ROOM	125,331	113,331	12,000	0	0	2.00
3.00	60.00	LABORATORY	27,000	0	27,000	0	0	3.00
4.00	90.01	JV CLINIC	466,388	466,388	0	0	0	4.00
5.00	91.00	EMERGENCY	1,269,736	0	1,269,736	0	0	5.00
6.00	93.00	BEHAVIOR HEALTH	16,095	16,095	0	0	0	6.00
7.00	90.04	WOMEN'S HEALTH CLINIC	392,202	392,202	0	0	0	7.00
8.00	90.05	ORTHO CLINIC	116,009	116,009	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,600,497	1,291,761	1,308,736		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.01	JV CLINIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	93.00	BEHAVIOR HEALTH	0	0	0	0	0	6.00
7.00	90.04	WOMEN'S HEALTH CLINIC	0	0	0	0	0	7.00
8.00	90.05	ORTHO CLINIC	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	187,736		1.00
2.00	50.00	OPERATING ROOM	0	0	0	113,331		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	90.01	JV CLINIC	0	0	0	466,388		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	93.00	BEHAVIOR HEALTH	0	0	0	16,095		6.00
7.00	90.04	WOMEN'S HEALTH CLINIC	0	0	0	392,202		7.00
8.00	90.05	ORTHO CLINIC	0	0	0	116,009		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,291,761		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	700,589	700,589				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,236,382		1,236,382			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,148,842	2,706	4,776	4,156,324		4.00
5.01	00590	IS/ACCOUNTING/MARKETING	1,282,987	8,326	14,693	178,763	1,484,769	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	1,089,661	38,394	67,757	210,835	1,406,647	5.02
5.03	00592	OTHER A&G	2,665,513	13,970	49,876	398,196	3,127,555	5.03
7.00	00700	OPERATION OF PLANT	1,277,444	60,446	106,674	123,774	1,568,338	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,511	4,111	7,255	14,431	110,308	8.00
9.00	00900	HOUSEKEEPING	438,700	2,122	3,746	99,301	543,869	9.00
10.00	01000	DIETARY	485,920	16,804	29,655	103,620	635,999	10.00
11.00	01100	CAFETERIA	0	12,255	21,627	0	33,882	11.00
13.00	01300	NURSING ADMINISTRATION	398,581	8,496	14,994	103,285	525,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,135	12,017	21,208	38,906	147,266	14.00
15.00	01500	PHARMACY	1,324,800	8,739	15,423	115,491	1,464,453	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	362,163	8,058	14,221	98,309	482,751	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,840,449	103,741	195,669	773,044	3,912,903	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	96,543	1,204	2,125	18,045	117,917	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	906,456	110,546	172,026	197,503	1,386,531	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,473	2,737	4,830	8,194	66,234	52.00
53.00	05300	ANESTHESIOLOGY	243	2,524	4,454	0	7,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	911,762	46,026	81,226	165,215	1,204,229	54.00
54.01	05401	ULTRASOUND	172,062	1,435	2,533	41,253	217,283	54.01
56.00	05600	RADIOISOTOPE	110,640	2,074	3,660	0	116,374	56.00
60.00	06000	LABORATORY	2,396,150	16,804	29,655	237,079	2,679,688	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	772	1,363	0	2,135	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	4,411	0	4,411	64.00
65.00	06500	RESPIRATORY THERAPY	545,144	9,700	17,119	135,056	707,019	65.00
66.00	06600	PHYSICAL THERAPY	719,078	27,440	48,427	198,647	993,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,495	1,028	1,814	48,388	223,725	67.00
68.00	06800	SPEECH PATHOLOGY	76,622	888	1,567	21,871	100,948	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,730	1,010	1,782	0	5,522	70.00
70.01	07001	CARDIOPULMONARY	54,309	7,055	12,450	15,149	88,963	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	817,303	0	0	0	817,303	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	131,458	0	0	0	131,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,399,072	17,880	31,555	277,328	1,725,835	88.00
90.00	09000	CLINIC	141,030	2,688	4,744	992	149,454	90.00
90.01	09001	JV CLINIC	651,936	16,256	28,689	32,539	729,420	90.01
90.02	09002	CLINIC - LAKESIDE	394,601	27,367	48,298	68,063	538,329	90.02
90.03	09003	CLINIC - QUICKCARE	207,073	20,136	35,536	44,001	306,746	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	104,074	7,134	0	8,504	119,712	90.04
90.05	09005	ORTHO CLINIC	73,567	3,728	0	49,131	126,426	90.05
91.00	09100	EMERGENCY	2,154,189	39,154	69,098	236,766	2,499,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	BEHAVIOR HEALTH	333,767	17,637	31,125	30,295	412,824	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,034,454	683,408	1,206,061	4,091,974	30,922,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,856	6,805	0	10,661	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,076	13,325	23,516	0	51,917	192.00
192.01	19201	MSO CLINICS	5,087	0	0	1,468	6,555	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	17,263	0	0	4,636	21,899	194.01
194.02	07952	MARKETING	127,313	0	0	33,133	160,446	194.02
194.03	07953	NONREIMBURSABLE - OTHER	86,157	0	0	25,106	111,263	194.03
194.04	07954	TH PAIN	19,734	0	0	7	19,741	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,305,084	700,589	1,236,382	4,156,324	31,305,084	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	IS/ACCOUNTING /MARKETING	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER A&G	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING	1,484,769					5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	70,448	1,477,095	1,477,095			5.02
5.03	00592	OTHER A&G	156,634	3,284,189	0	3,284,189	3,284,189	5.03
7.00	00700	OPERATION OF PLANT	78,546	1,646,884	0	1,646,884	193,023	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,524	115,832	0	115,832	13,576	8.00
9.00	00900	HOUSEKEEPING	27,238	571,107	0	571,107	66,937	9.00
10.00	01000	DIETARY	31,852	667,851	0	667,851	78,275	10.00
11.00	01100	CAFETERIA	1,697	35,579	0	35,579	4,170	11.00
13.00	01300	NURSING ADMINISTRATION	26,311	551,667	0	551,667	64,658	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,375	154,641	10,333	164,974	19,336	14.00
15.00	01500	PHARMACY	73,343	1,537,796	102,756	1,640,552	192,281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,177	506,928	0	506,928	59,414	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	195,980	4,108,883	274,551	4,383,434	513,760	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	5,906	123,823	8,274	132,097	15,482	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,440	1,455,971	97,288	1,553,259	182,050	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,317	69,551	4,647	74,198	8,696	52.00
53.00	05300	ANESTHESIOLOGY	362	7,583	507	8,090	948	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,310	1,264,539	84,496	1,349,035	158,114	54.00
54.01	05401	ULTRASOUND	10,882	228,165	15,246	243,411	28,529	54.01
56.00	05600	RADIOISOTOPE	5,828	122,202	8,166	130,368	15,280	56.00
60.00	06000	LABORATORY	134,204	2,813,892	188,024	3,001,916	351,840	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	107	2,242	150	2,392	280	63.00
64.00	06400	INTRAVENOUS THERAPY	221	4,632	310	4,942	579	64.00
65.00	06500	RESPIRATORY THERAPY	35,409	742,428	49,609	792,037	92,831	65.00
66.00	06600	PHYSICAL THERAPY	49,761	1,043,353	69,717	1,113,070	130,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,205	234,930	15,698	250,628	29,375	67.00
68.00	06800	SPEECH PATHOLOGY	5,056	106,004	7,083	113,087	13,254	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	277	5,799	387	6,186	725	70.00
70.01	07001	CARDIOPULMONARY	4,455	93,418	6,242	99,660	11,681	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,932	858,235	57,347	915,582	107,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,584	138,042	9,224	147,266	17,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	86,433	1,812,268	121,096	1,933,364	226,600	88.00
90.00	09000	CLINIC	7,485	156,939	10,487	167,426	19,623	90.00
90.01	09001	JV CLINIC	36,531	765,951	51,181	817,132	95,772	90.01
90.02	09002	CLINIC - LAKESIDE	26,961	565,290	37,773	603,063	70,682	90.02
90.03	09003	CLINIC - QUICKCARE	15,362	322,108	21,523	343,631	40,275	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	5,995	125,707	8,400	134,107	15,718	90.04
90.05	09005	ORTHO CLINIC	6,332	132,758	8,871	141,629	16,600	90.05
91.00	09100	EMERGENCY	125,165	2,624,372	175,361	2,799,733	328,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
93.00	04950	BEHAVIOR HEALTH	20,675	433,499	28,966	462,465	54,203	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,474,320	30,912,153	1,473,713	30,908,771	3,237,738	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,661	0	10,661	1,250	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,917	0	51,917	6,085	192.00
192.01	19201	MSO CLINICS	328	6,883	460	7,343	861	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	1,097	22,996	1,537	24,533	2,875	194.01
194.02	07952	MARKETING	8,035	168,481	0	168,481	19,747	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	111,263	0	111,263	13,041	194.03
194.04	07954	TH PAIN	989	20,730	1,385	22,115	2,592	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,484,769	31,305,084	1,477,095	31,305,084	3,284,189	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT	1,839,907					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,449	142,857				8.00
9.00	00900	HOUSEKEEPING	6,943	26,955	671,942			9.00
10.00	01000	DIETARY	54,969	1,844	17,574	820,513		10.00
11.00	01100	CAFETERIA	40,088	1,309	12,816	438,214	532,176	11.00
13.00	01300	NURSING ADMINISTRATION	27,793	0	8,885	0	6,879	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,312	0	12,568	0	6,742	14.00
15.00	01500	PHARMACY	28,588	0	9,140	0	15,799	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,360	0	8,427	0	15,685	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	362,696	38,366	115,956	192,589	135,568	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,939	1,415	1,259	0	2,660	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	318,870	12,614	101,944	13,591	41,619	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,953	3,511	2,862	0	1,215	52.00
53.00	05300	ANESTHESIOLOGY	8,256	0	2,640	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,562	12,949	48,135	0	31,094	54.00
54.01	05401	ULTRASOUND	4,695	0	1,501	0	11,534	54.01
56.00	05600	RADIOISOTOPE	6,784	0	2,169	0	0	56.00
60.00	06000	LABORATORY	54,969	535	17,574	0	48,934	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,527	0	808	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,177	0	2,614	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,732	3,642	10,145	0	22,885	65.00
66.00	06600	PHYSICAL THERAPY	89,764	8,307	28,698	0	20,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,362	0	1,075	0	4,059	67.00
68.00	06800	SPEECH PATHOLOGY	2,905	0	929	0	2,178	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,302	0	1,056	0	0	70.00
70.01	07001	CARDIOPULMONARY	23,078	0	7,378	0	1,628	70.01
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	58,490	0	18,700	0	26,026	88.00
90.00	09000	CLINIC	8,793	0	2,811	0	321	90.00
90.01	09001	JV CLINIC	53,178	5,972	17,001	0	22,633	90.01
90.02	09002	CLINIC - LAKESIDE	89,525	0	28,622	0	23,114	90.02
90.03	09003	CLINIC - QUICKCARE	65,871	0	21,059	0	10,938	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	0	0	5,847	90.04
90.05	09005	ORTHO CLINIC	0	0	0	0	5,710	90.05
91.00	09100	EMERGENCY	128,081	25,438	40,948	0	43,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	57,694	0	18,445	10,824	5,847	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,783,705	142,857	563,739	655,218	513,213	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,613	0	4,032	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,589	0	13,936	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	9,768	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	165,295	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	0	0	8,668	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	90,235	0	527	194.03
194.04	07954	TH PAIN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,839,907	142,857	671,942	820,513	532,176	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
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	659,882					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	242,932				14.00
15.00	01500	PHARMACY	0	5,184	1,891,544			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	0	616,827		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	351,507	4,752	0	45,075	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	9,737	175	0	1,274	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104,088	17,174	0	39,144	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,542	0	808	0	52.00
53.00	05300	ANESTHESIOLOGY	0	42	0	4,227	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,368	0	107,953	0	54.00
54.01	05401	ULTRASOUND	0	712	0	23,200	0	54.01
56.00	05600	RADIOISOTOPE	0	194	0	3,475	0	56.00
60.00	06000	LABORATORY	0	24,309	0	119,941	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,385	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	265	0	7,299	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,709	0	15,698	0	65.00
66.00	06600	PHYSICAL THERAPY	0	681	0	14,019	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13	0	4,099	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	15	0	844	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	241	0	70.00
70.01	07001	CARDIOPULMONARY	5,880	261	0	1,328	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	114,851	0	38,431	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	22,793	0	4,660	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,891,544	37,182	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,230	0	19,400	0	88.00
90.00	09000	CLINIC	1,207	7	0	3,150	0	90.00
90.01	09001	JV CLINIC	82,563	1,512	0	30,753	0	90.01
90.02	09002	CLINIC - LAKESIDE	0	24,929	0	8,762	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	2,023	0	5,183	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	0	2,492	0	90.04
90.05	09005	ORTHO CLINIC	0	0	0	3,819	0	90.05
91.00	09100	EMERGENCY	104,900	1,070	0	64,741	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	0	613	0	4,244	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	659,882	242,437	1,891,544	616,827	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	287	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	208	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0	0	194.03
194.04	07954	TH PAIN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	659,882	242,932	1,891,544	616,827	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	IS/ACCOUNTING/MARKETING					5.01
5.02	00591	BUSINESS OFFICE & ADMITTING					5.02
5.03	00592	OTHER A&G					5.03
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
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,143,703	0	6,143,703		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	168,038	0	168,038		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,384,353	0	2,384,353		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,785	0	101,785		52.00
53.00	05300	ANESTHESIOLOGY	24,203	0	24,203		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,863,210	0	1,863,210		54.00
54.01	05401	ULTRASOUND	313,582	0	313,582		54.01
56.00	05600	RADIOISOTOPE	158,270	0	158,270		56.00
60.00	06000	LABORATORY	3,620,018	0	3,620,018		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,392	0	11,392		63.00
64.00	06400	INTRAVENOUS THERAPY	23,876	0	23,876		64.00
65.00	06500	RESPIRATORY THERAPY	980,679	0	980,679		65.00
66.00	06600	PHYSICAL THERAPY	1,405,634	0	1,405,634		66.00
67.00	06700	OCCUPATIONAL THERAPY	292,611	0	292,611		67.00
68.00	06800	SPEECH PATHOLOGY	133,212	0	133,212		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,510	0	11,510		70.00
70.01	07001	CARDIOPULMONARY	150,894	0	150,894		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,176,175	0	1,176,175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	191,979	0	191,979		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,928,726	0	1,928,726		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,284,810	0	2,284,810		88.00
90.00	09000	CLINIC	203,338	0	203,338		90.00
90.01	09001	JV CLINIC	1,126,516	0	1,126,516		90.01
90.02	09002	CLINIC - LAKESIDE	848,697	0	848,697		90.02
90.03	09003	CLINIC - QUICKCARE	488,980	0	488,980		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	158,164	0	158,164		90.04
90.05	09005	ORTHO CLINIC	167,758	0	167,758		90.05
91.00	09100	EMERGENCY	3,536,714	0	3,536,714		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04950	BEHAVIOR HEALTH	614,335	0	614,335		93.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,513,162	0	30,513,162		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,556	0	28,556		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,814	0	115,814		192.00
192.01	19201	MSO CLINICS	17,972	0	17,972		192.01
192.03	19203	FPA	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	165,295	0	165,295		194.00
194.01	07951	WELLNESS CLINIC	36,284	0	36,284		194.01
194.02	07952	MARKETING	188,228	0	188,228		194.02
194.03	07953	NONREIMBURSABLE - OTHER	215,066	0	215,066		194.03
194.04	07954	TH PAIN	24,707	0	24,707		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	31,305,084	0	31,305,084		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,706	4,776	7,482	7,482	4.00
5.01	00590	IS/ACCOUNTING/MARKETING	0	8,326	14,693	23,019	322	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	0	38,394	67,757	106,151	380	5.02
5.03	00592	OTHER A&G	0	13,970	49,876	63,846	717	5.03
7.00	00700	OPERATION OF PLANT	0	60,446	106,674	167,120	223	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,111	7,255	11,366	26	8.00
9.00	00900	HOUSEKEEPING	0	2,122	3,746	5,868	179	9.00
10.00	01000	DIETARY	0	16,804	29,655	46,459	187	10.00
11.00	01100	CAFETERIA	0	12,255	21,627	33,882	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,496	14,994	23,490	186	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,017	21,208	33,225	70	14.00
15.00	01500	PHARMACY	0	8,739	15,423	24,162	208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,058	14,221	22,279	177	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	103,741	195,669	299,410	1,385	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,204	2,125	3,329	33	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	110,546	172,026	282,572	356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,737	4,830	7,567	15	52.00
53.00	05300	ANESTHESIOLOGY	0	2,524	4,454	6,978	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,026	81,226	127,252	298	54.00
54.01	05401	ULTRASOUND	0	1,435	2,533	3,968	74	54.01
56.00	05600	RADIOISOTOPE	0	2,074	3,660	5,734	0	56.00
60.00	06000	LABORATORY	0	16,804	29,655	46,459	427	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	772	1,363	2,135	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	4,411	4,411	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,700	17,119	26,819	243	65.00
66.00	06600	PHYSICAL THERAPY	0	27,440	48,427	75,867	358	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,028	1,814	2,842	87	67.00
68.00	06800	SPEECH PATHOLOGY	0	888	1,567	2,455	39	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,010	1,782	2,792	0	70.00
70.01	07001	CARDIOPULMONARY	0	7,055	12,450	19,505	27	70.01
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,880	31,555	49,435	500	88.00
90.00	09000	CLINIC	0	2,688	4,744	7,432	2	90.00
90.01	09001	JV CLINIC	0	16,256	28,689	44,945	59	90.01
90.02	09002	CLINIC - LAKESIDE	0	27,367	48,298	75,665	123	90.02
90.03	09003	CLINIC - QUICKCARE	0	20,136	35,536	55,672	79	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	7,134	0	7,134	15	90.04
90.05	09005	ORTHO CLINIC	0	3,728	0	3,728	89	90.05
91.00	09100	EMERGENCY	0	39,154	69,098	108,252	427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	BEHAVIOR HEALTH	0	17,637	31,125	48,762	55	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	683,408	1,206,061	1,889,469	7,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,856	6,805	10,661	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,325	23,516	36,841	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	3	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	0	0	8	194.01
194.02	07952	MARKETING	0	0	0	0	60	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0	45	194.03
194.04	07954	TH PAIN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	700,589	1,236,382	1,936,971	7,482	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	IS/ACCOUNTING /MARKETING	BUSINESS OFFICE & ADMITTING	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING	23,341					5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	1,107	107,638				5.02
5.03	00592	OTHER A&G	2,461	0	67,024			5.03
7.00	00700	OPERATION OF PLANT	1,234	0	3,939	172,516		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87	0	277	1,261	13,017	8.00
9.00	00900	HOUSEKEEPING	428	0	1,366	651	2,456	9.00
10.00	01000	DIETARY	501	0	1,597	5,154	168	10.00
11.00	01100	CAFETERIA	27	0	85	3,759	119	11.00
13.00	01300	NURSING ADMINISTRATION	413	0	1,320	2,606	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	116	753	395	3,686	0	14.00
15.00	01500	PHARMACY	1,153	7,488	3,924	2,681	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380	0	1,213	2,472	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,090	20,011	10,481	34,009	3,496	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	93	603	316	369	129	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,091	7,089	3,715	29,898	1,149	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52	339	177	839	320	52.00
53.00	05300	ANESTHESIOLOGY	6	37	19	774	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	948	6,157	3,227	14,117	1,180	54.00
54.01	05401	ULTRASOUND	171	1,111	582	440	0	54.01
56.00	05600	RADIOISOTOPE	92	595	312	636	0	56.00
60.00	06000	LABORATORY	2,109	13,701	7,181	5,154	49	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2	11	6	237	0	63.00
64.00	06400	INTRAVENOUS THERAPY	3	23	12	767	0	64.00
65.00	06500	RESPIRATORY THERAPY	556	3,615	1,895	2,975	332	65.00
66.00	06600	PHYSICAL THERAPY	782	5,080	2,662	8,417	757	66.00
67.00	06700	OCCUPATIONAL THERAPY	176	1,144	600	315	0	67.00
68.00	06800	SPEECH PATHOLOGY	79	516	271	272	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4	28	15	310	0	70.00
70.01	07001	CARDIOPULMONARY	70	455	238	2,164	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	643	4,179	2,190	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	103	672	352	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,358	8,824	4,625	5,484	0	88.00
90.00	09000	CLINIC	118	764	400	824	0	90.00
90.01	09001	JV CLINIC	574	3,729	1,955	4,986	544	90.01
90.02	09002	CLINIC - LAKESIDE	424	2,752	1,443	8,394	0	90.02
90.03	09003	CLINIC - QUICKCARE	241	1,568	822	6,176	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	94	612	321	0	0	90.04
90.05	09005	ORTHO CLINIC	99	646	339	0	0	90.05
91.00	09100	EMERGENCY	1,967	12,778	6,697	12,009	2,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	325	2,111	1,106	5,410	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,177	107,391	66,075	167,246	13,017	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	26	1,183	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	124	4,087	0	192.00
192.01	19201	MSO CLINICS	5	34	18	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	17	112	59	0	0	194.01
194.02	07952	MARKETING	126	0	403	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	266	0	0	194.03
194.04	07954	TH PAIN	16	101	53	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,341	107,638	67,024	172,516	13,017	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	10,948					9.00
10.00	01000	DIETARY	286	54,352				10.00
11.00	01100	CAFETERIA	209	29,029	67,110			11.00
13.00	01300	NURSING ADMINISTRATION	145	0	868	29,028		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	205	0	850	0	39,300	14.00
15.00	01500	PHARMACY	149	0	1,992	0	839	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137	0	1,978	0	2	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,889	12,757	17,096	15,462	769	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	21	0	335	428	28	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,661	900	5,248	4,579	2,778	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47	0	153	0	249	52.00
53.00	05300	ANESTHESIOLOGY	43	0	0	0	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784	0	3,921	0	868	54.00
54.01	05401	ULTRASOUND	24	0	1,455	0	115	54.01
56.00	05600	RADIOISOTOPE	35	0	0	0	31	56.00
60.00	06000	LABORATORY	286	0	6,171	0	3,933	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	13	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	43	0	0	0	43	64.00
65.00	06500	RESPIRATORY THERAPY	165	0	2,886	0	1,894	65.00
66.00	06600	PHYSICAL THERAPY	468	0	2,603	0	110	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	0	512	0	2	67.00
68.00	06800	SPEECH PATHOLOGY	15	0	275	0	2	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	120	0	205	259	42	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	305	0	3,282	0	361	88.00
90.00	09000	CLINIC	46	0	40	53	1	90.00
90.01	09001	JV CLINIC	277	0	2,854	3,632	245	90.01
90.02	09002	CLINIC - LAKESIDE	466	0	2,915	0	4,033	90.02
90.03	09003	CLINIC - QUICKCARE	343	0	1,379	0	327	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	737	0	0	90.04
90.05	09005	ORTHO CLINIC	0	0	720	0	0	90.05
91.00	09100	EMERGENCY	667	0	5,506	4,615	173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	301	717	737	0	99	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,185	43,403	64,718	29,028	39,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	66	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	227	0	0	0	46	192.00
192.01	19201	MSO CLINICS	0	0	1,232	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	10,949	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	1,093	0	34	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	1,470	0	67	0	0	194.03
194.04	07954	TH PAIN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,948	54,352	67,110	29,028	39,300	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
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	42,596					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,638				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,092		421,947	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		0	0	31.00
43.00	04300	NURSERY	0	59		5,743	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,817		342,853	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38		9,796	0	52.00
53.00	05300	ANESTHESIOLOGY	0	196		8,060	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,011		163,763	0	54.00
54.01	05401	ULTRASOUND	0	1,077		9,017	0	54.01
56.00	05600	RADIOISOTOPE	0	161		7,596	0	56.00
60.00	06000	LABORATORY	0	5,572		91,042	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	250		2,654	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	339		5,641	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	729		42,109	0	65.00
66.00	06600	PHYSICAL THERAPY	0	651		97,755	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	190		5,886	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	39		3,963	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11		3,177	0	70.00
70.01	07001	CARDIOPULMONARY	0	62		23,147	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,784		27,378	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	216		5,030	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,596	1,726		44,322	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	901		75,075	0	88.00
90.00	09000	CLINIC	0	146		9,826	0	90.00
90.01	09001	JV CLINIC	0	1,428		65,228	0	90.01
90.02	09002	CLINIC - LAKESIDE	0	407		96,622	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	241		66,848	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	116		9,029	0	90.04
90.05	09005	ORTHO CLINIC	0	177		5,798	0	90.05
91.00	09100	EMERGENCY	0	3,005		158,414	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	BEHAVIOR HEALTH	0	197		59,820	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0		0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,596	28,638	0	1,867,539	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		11,936	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		41,325	0	192.00
192.01	19201	MSO CLINICS	0	0		1,292	0	192.01
192.03	19203	FPA	0	0		0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0		10,949	0	194.00
194.01	07951	WELLNESS CLINIC	0	0		1,323	0	194.01
194.02	07952	MARKETING	0	0		589	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0		1,848	0	194.03
194.04	07954	TH PAIN	0	0		170	0	194.04
200.00		Cross Foot Adjustments			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)	42,596	28,638	0	1,936,971	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	IS/ACCOUNTING/MARKETING			5.01
5.02	00591	BUSINESS OFFICE & ADMITTING			5.02
5.03	00592	OTHER A&G			5.03
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
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	421,947		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	5,743		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	342,853		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,796		52.00
53.00	05300	ANESTHESIOLOGY	8,060		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,763		54.00
54.01	05401	ULTRASOUND	9,017		54.01
56.00	05600	RADIOISOTOPE	7,596		56.00
60.00	06000	LABORATORY	91,042		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,654		63.00
64.00	06400	INTRAVENOUS THERAPY	5,641		64.00
65.00	06500	RESPIRATORY THERAPY	42,109		65.00
66.00	06600	PHYSICAL THERAPY	97,755		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,886		67.00
68.00	06800	SPEECH PATHOLOGY	3,963		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,177		70.00
70.01	07001	CARDIOPULMONARY	23,147		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,378		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,030		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,322		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	75,075		88.00
90.00	09000	CLINIC	9,826		90.00
90.01	09001	JV CLINIC	65,228		90.01
90.02	09002	CLINIC - LAKESIDE	96,622		90.02
90.03	09003	CLINIC - QUICKCARE	66,848		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	9,029		90.04
90.05	09005	ORTHO CLINIC	5,798		90.05
91.00	09100	EMERGENCY	158,414		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	BEHAVIOR HEALTH	59,820		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,867,539		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,936		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,325		192.00
192.01	19201	MSO CLINICS	1,292		192.01
192.03	19203	FPA	0		192.03
194.00	07950	MEALS ON WHEELS	10,949		194.00
194.01	07951	WELLNESS CLINIC	1,323		194.01
194.02	07952	MARKETING	589		194.02
194.03	07953	NONREIMBURSABLE - OTHER	1,848		194.03
194.04	07954	TH PAIN	170		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,936,971		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	IS/ACCOUNTING /MARKETING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	115,197					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		115,196				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	445	445	14,401,377			4.00
5.01	00590	IS/ACCOUNTING/MARKETING	1,369	1,369	619,400	-1,484,769	29,646,474	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	6,313	6,313	730,529	0	1,406,647	5.02
5.03	00592	OTHER A&G	2,297	4,647	1,379,723	0	3,127,555	5.03
7.00	00700	OPERATION OF PLANT	9,939	9,939	428,870	0	1,568,338	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	676	50,002	0	110,308	8.00
9.00	00900	HOUSEKEEPING	349	349	344,070	0	543,869	9.00
10.00	01000	DIETARY	2,763	2,763	359,035	0	635,999	10.00
11.00	01100	CAFETERIA	2,015	2,015	0	0	33,882	11.00
13.00	01300	NURSING ADMINISTRATION	1,397	1,397	357,874	0	525,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,976	1,976	134,806	0	147,266	14.00
15.00	01500	PHARMACY	1,437	1,437	400,167	0	1,464,453	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,325	1,325	340,634	0	482,751	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,058	18,231	2,678,559	0	3,912,903	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	198	198	62,523	0	117,917	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,177	16,028	684,334	0	1,386,531	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	450	450	28,391	0	66,234	52.00
53.00	05300	ANESTHESIOLOGY	415	415	0	0	7,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,568	7,568	572,457	0	1,204,229	54.00
54.01	05401	ULTRASOUND	236	236	142,940	0	217,283	54.01
56.00	05600	RADIOISOTOPE	341	341	0	0	116,374	56.00
60.00	06000	LABORATORY	2,763	2,763	821,461	0	2,679,688	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	127	127	0	0	2,135	63.00
64.00	06400	INTRAVENOUS THERAPY	0	411	0	0	4,411	64.00
65.00	06500	RESPIRATORY THERAPY	1,595	1,595	467,959	0	707,019	65.00
66.00	06600	PHYSICAL THERAPY	4,512	4,512	688,297	0	993,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	169	169	167,660	0	223,725	67.00
68.00	06800	SPEECH PATHOLOGY	146	146	75,781	0	100,948	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166	166	0	0	5,522	70.00
70.01	07001	CARDIOPULMONARY	1,160	1,160	52,489	0	88,963	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	817,303	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	131,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,940	2,940	960,921	0	1,725,835	88.00
90.00	09000	CLINIC	442	442	3,438	0	149,454	90.00
90.01	09001	JV CLINIC	2,673	2,673	112,747	0	729,420	90.01
90.02	09002	CLINIC - LAKESIDE	4,500	4,500	235,832	0	538,329	90.02
90.03	09003	CLINIC - QUICKCARE	3,311	3,311	152,462	0	306,746	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	1,173	0	29,466	0	119,712	90.04
90.05	09005	ORTHO CLINIC	613	0	170,235	0	126,426	90.05
91.00	09100	EMERGENCY	6,438	6,438	820,378	0	2,499,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	2,900	2,900	104,970	0	412,824	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,372	112,371	14,178,410	-1,484,769	29,437,833	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	634	634	0	-10,661	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,191	2,191	0	-51,917	0	192.00
192.01	19201	MSO CLINICS	0	0	5,087	0	6,555	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	16,064	0	21,899	194.01
194.02	07952	MARKETING	0	0	114,802	0	160,446	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	86,991	-111,263	0	194.03
194.04	07954	TH PAIN	0	0	23	0	19,741	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	700,589	1,236,382	4,156,324		1,484,769	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.081660	10.732855	0.288606		0.050082	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	IS/ACCOUNTING /MARKETING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
204.00		Cost to be allocated (per Wkst. B, Part II)			7,482		23,341	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000520		0.000787	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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	-1,477,095	22,105,630				5.02
5.03	00592	OTHER A&G	-3,284,189	0	-3,284,189	28,020,895		5.03
7.00	00700	OPERATION OF PLANT	-1,646,884	0	0	1,646,884	92,483	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-115,832	0	0	115,832	676	8.00
9.00	00900	HOUSEKEEPING	-571,107	0	0	571,107	349	9.00
10.00	01000	DIETARY	-667,851	0	0	667,851	2,763	10.00
11.00	01100	CAFETERIA	-35,579	0	0	35,579	2,015	11.00
13.00	01300	NURSING ADMINISTRATION	-551,667	0	0	551,667	1,397	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	154,641	0	164,974	1,976	14.00
15.00	01500	PHARMACY	0	1,537,796	0	1,640,552	1,437	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-506,928	0	0	506,928	1,325	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,108,883	0	4,383,434	18,231	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	123,823	0	132,097	198	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,455,971	0	1,553,259	16,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	69,551	0	74,198	450	52.00
53.00	05300	ANESTHESIOLOGY	0	7,583	0	8,090	415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,264,539	0	1,349,035	7,568	54.00
54.01	05401	ULTRASOUND	0	228,165	0	243,411	236	54.01
56.00	05600	RADIOISOTOPE	0	122,202	0	130,368	341	56.00
60.00	06000	LABORATORY	0	2,813,892	0	3,001,916	2,763	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,242	0	2,392	127	63.00
64.00	06400	INTRAVENOUS THERAPY	0	4,632	0	4,942	411	64.00
65.00	06500	RESPIRATORY THERAPY	0	742,428	0	792,037	1,595	65.00
66.00	06600	PHYSICAL THERAPY	0	1,043,353	0	1,113,070	4,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234,930	0	250,628	169	67.00
68.00	06800	SPEECH PATHOLOGY	0	106,004	0	113,087	146	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,799	0	6,186	166	70.00
70.01	07001	CARDIOPULMONARY	0	93,418	0	99,660	1,160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	858,235	0	915,582	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	138,042	0	147,266	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,812,268	0	1,933,364	2,940	88.00
90.00	09000	CLINIC	0	156,939	0	167,426	442	90.00
90.01	09001	JV CLINIC	0	765,951	0	817,132	2,673	90.01
90.02	09002	CLINIC - LAKESIDE	0	565,290	0	603,063	4,500	90.02
90.03	09003	CLINIC - QUICKCARE	0	322,108	0	343,631	3,311	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	125,707	0	134,107	0	90.04
90.05	09005	ORTHO CLINIC	0	132,758	0	141,629	0	90.05
91.00	09100	EMERGENCY	0	2,624,372	0	2,799,733	6,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	0	433,499	0	462,465	2,900	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,857,132	22,055,021	-3,284,189	27,624,582	89,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-10,661	0	0	10,661	634	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-51,917	0	0	51,917	2,191	192.00
192.01	19201	MSO CLINICS	0	6,883	0	7,343	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	22,996	0	24,533	0	194.01
194.02	07952	MARKETING	-168,481	0	0	168,481	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	-111,263	0	0	111,263	0	194.03
194.04	07954	TH PAIN	0	20,730	0	22,115	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,477,095		3,284,189	1,839,907	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.066820		0.117205	19.894543	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	7.00	
204.00		Cost to be allocated (per Wkst. B, Part II)		107,638		67,024	172,516	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004869		0.002392	1.865381	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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	156,098					8.00
9.00	00900	HOUSEKEEPING	29,453	105,645				9.00
10.00	01000	DIETARY	2,015	2,763	43,891			10.00
11.00	01100	CAFETERIA	1,430	2,015	23,441	23,208		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,397	0	300	164,077	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,976	0	294	0	14.00
15.00	01500	PHARMACY	0	1,437	0	689	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,325	0	684	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,923	18,231	10,302	5,912	87,401	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,546	198	0	116	2,421	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,783	16,028	727	1,815	25,881	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,836	450	0	53	0	52.00
53.00	05300	ANESTHESIOLOGY	0	415	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,149	7,568	0	1,356	0	54.00
54.01	05401	ULTRASOUND	0	236	0	503	0	54.01
56.00	05600	RADIOISOTOPE	0	341	0	0	0	56.00
60.00	06000	LABORATORY	585	2,763	0	2,134	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	127	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	411	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,980	1,595	0	998	0	65.00
66.00	06600	PHYSICAL THERAPY	9,077	4,512	0	900	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	169	0	177	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	146	0	95	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	166	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	1,160	0	71	1,462	70.01
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,940	0	1,135	0	88.00
90.00	09000	CLINIC	0	442	0	14	300	90.00
90.01	09001	JV CLINIC	6,525	2,673	0	987	20,529	90.01
90.02	09002	CLINIC - LAKESIDE	0	4,500	0	1,008	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	3,311	0	477	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	0	255	0	90.04
90.05	09005	ORTHO CLINIC	0	0	0	249	0	90.05
91.00	09100	EMERGENCY	27,796	6,438	0	1,904	26,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	0	2,900	579	255	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,098	88,633	35,049	22,381	164,077	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	634	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,191	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	426	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	8,842	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	0	378	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	14,187	0	23	0	194.03
194.04	07954	TH PAIN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	142,857	671,942	820,513	532,176	659,882	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.915175	6.360377	18.694334	22.930714	4.021782	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	13,017	10,948	54,352	67,110	29,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.083390	0.103630	1.238340	2.891675	0.176917	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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
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	1,401,125					14.00
15.00	01500	PHARMACY	29,898	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75	0	97,057,562			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,406	0	7,092,816	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	1,011	0	200,438	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	99,051	0	6,159,585	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,891	0	127,136	0		52.00
53.00	05300	ANESTHESIOLOGY	243	0	665,124	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,961	0	16,987,062	0		54.00
54.01	05401	ULTRASOUND	4,108	0	3,650,627	0		54.01
56.00	05600	RADIOISOTOPE	1,119	0	546,863	0		56.00
60.00	06000	LABORATORY	140,202	0	18,869,171	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	847,413	0		63.00
64.00	06400	INTRAVENOUS THERAPY	1,530	0	1,148,583	0		64.00
65.00	06500	RESPIRATORY THERAPY	67,534	0	2,470,127	0		65.00
66.00	06600	PHYSICAL THERAPY	3,930	0	2,205,968	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	77	0	644,999	0		67.00
68.00	06800	SPEECH PATHOLOGY	87	0	132,850	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	37,908	0		70.00
70.01	07001	CARDIOPULMONARY	1,504	0	208,912	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	662,405	0	6,047,420	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	131,458	0	733,229	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	5,850,795	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,861	0	3,052,737	0		88.00
90.00	09000	CLINIC	42	0	495,732	0		90.00
90.01	09001	JV CLINIC	8,722	0	4,839,251	0		90.01
90.02	09002	CLINIC - LAKESIDE	143,782	0	1,378,764	0		90.02
90.03	09003	CLINIC - QUICKCARE	11,667	0	815,583	0		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	392,117	0		90.04
90.05	09005	ORTHO CLINIC	0	0	600,997	0		90.05
91.00	09100	EMERGENCY	6,169	0	10,187,458	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	BEHAVIOR HEALTH	3,536	0	667,897	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,398,269	100	97,057,562	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,657	0	0	0		192.00
192.01	19201	MSO CLINICS	0	0	0	0		192.01
192.03	19203	FPA	0	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0		194.00
194.01	07951	WELLNESS CLINIC	1,199	0	0	0		194.01
194.02	07952	MARKETING	0	0	0	0		194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0		194.03
194.04	07954	TH PAIN	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	242,932	1,891,544	616,827	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.173384	18,915.440000	0.006355	0.000000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 9:17 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	39,300	42,596	28,638	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028049	425.960000	0.000295	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,143,703		6,143,703	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	168,038		168,038	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,384,353		2,384,353	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,785		101,785	0	0	52.00
53.00	05300	ANESTHESIOLOGY	24,203		24,203	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,863,210		1,863,210	0	0	54.00
54.01	05401	ULTRASOUND	313,582		313,582	0	0	54.01
56.00	05600	RADIOISOTOPE	158,270		158,270	0	0	56.00
60.00	06000	LABORATORY	3,620,018		3,620,018	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,392		11,392	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	23,876		23,876	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	980,679	0	980,679	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,405,634	0	1,405,634	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,611	0	292,611	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	133,212	0	133,212	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,510		11,510	0	0	70.00
70.01	07001	CARDIOPULMONARY	150,894		150,894	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,176,175		1,176,175	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	191,979		191,979	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,928,726		1,928,726	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,284,810		2,284,810	0	0	88.00
90.00	09000	CLINIC	203,338		203,338	0	0	90.00
90.01	09001	JV CLINIC	1,126,516		1,126,516	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	848,697		848,697	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	488,980		488,980	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	158,164		158,164	0	0	90.04
90.05	09005	ORTHO CLINIC	167,758		167,758	0	0	90.05
91.00	09100	EMERGENCY	3,536,714		3,536,714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,106,105		2,106,105		0	92.00
93.00	04950	BEHAVIOR HEALTH	614,335		614,335	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	32,619,267	0	32,619,267	0	0	200.00
201.00		Less Observation Beds	2,106,105		2,106,105		0	201.00
202.00		Total (see instructions)	30,513,162	0	30,513,162	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,551,602		4,551,602			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	200,438		200,438			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	637,779	5,521,806	6,159,585	0.387096	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,060	108,076	127,136	0.800599	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	146,435	518,689	665,124	0.036389	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,764	16,389,298	16,987,062	0.109684	0.000000	54.00
54.01	05401	ULTRASOUND	158,154	3,492,473	3,650,627	0.085898	0.000000	54.01
56.00	05600	RADIOISOTOPE	7,920	538,943	546,863	0.289414	0.000000	56.00
60.00	06000	LABORATORY	1,164,304	17,704,867	18,869,171	0.191848	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	288,108	559,305	847,413	0.013443	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	7,425	1,141,158	1,148,583	0.020787	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	538,147	1,931,980	2,470,127	0.397016	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	132,894	2,073,074	2,205,968	0.637196	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,902	614,097	644,999	0.453661	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,146	126,704	132,850	1.002725	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,804	31,104	37,908	0.303630	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	208,912	208,912	0.722285	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,033,853	4,013,567	6,047,420	0.194492	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	80,045	653,184	733,229	0.261827	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,392,151	4,458,644	5,850,795	0.329652	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,052,737	3,052,737			88.00
90.00	09000	CLINIC	0	495,732	495,732	0.410177	0.000000	90.00
90.01	09001	JV CLINIC	0	4,839,251	4,839,251	0.232787	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0	1,378,764	1,378,764	0.615549	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0	815,583	815,583	0.599547	0.000000	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	392,117	392,117	0.403359	0.000000	90.04
90.05	09005	ORTHO CLINIC	0	600,997	600,997	0.279133	0.000000	90.05
91.00	09100	EMERGENCY	358,319	9,829,139	10,187,458	0.347164	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	80,568	2,460,646	2,541,214	0.828779	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	4,080	663,817	667,897	0.919805	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	12,442,898	84,614,664	97,057,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,442,898	84,614,664	97,057,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
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
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	JV CLINIC	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0.000000	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.000000	90.04
90.05	09005	ORTHO CLINIC	0.000000	90.05
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,143,703		6,143,703	0	6,143,703	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	168,038		168,038	0	168,038	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,384,353		2,384,353	0	2,384,353	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,785		101,785	0	101,785	52.00
53.00	05300	ANESTHESIOLOGY	24,203		24,203	0	24,203	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,863,210		1,863,210	0	1,863,210	54.00
54.01	05401	ULTRASOUND	313,582		313,582	0	313,582	54.01
56.00	05600	RADIOISOTOPE	158,270		158,270	0	158,270	56.00
60.00	06000	LABORATORY	3,620,018		3,620,018	0	3,620,018	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,392		11,392	0	11,392	63.00
64.00	06400	INTRAVENOUS THERAPY	23,876		23,876	0	23,876	64.00
65.00	06500	RESPIRATORY THERAPY	980,679	0	980,679	0	980,679	65.00
66.00	06600	PHYSICAL THERAPY	1,405,634	0	1,405,634	0	1,405,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,611	0	292,611	0	292,611	67.00
68.00	06800	SPEECH PATHOLOGY	133,212	0	133,212	0	133,212	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,510		11,510	0	11,510	70.00
70.01	07001	CARDIOPULMONARY	150,894		150,894	0	150,894	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,176,175		1,176,175	0	1,176,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	191,979		191,979	0	191,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,928,726		1,928,726	0	1,928,726	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,284,810		2,284,810	0	2,284,810	88.00
90.00	09000	CLINIC	203,338		203,338	0	203,338	90.00
90.01	09001	JV CLINIC	1,126,516		1,126,516	0	1,126,516	90.01
90.02	09002	CLINIC - LAKESIDE	848,697		848,697	0	848,697	90.02
90.03	09003	CLINIC - QUICKCARE	488,980		488,980	0	488,980	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	158,164		158,164	0	158,164	90.04
90.05	09005	ORTHO CLINIC	167,758		167,758	0	167,758	90.05
91.00	09100	EMERGENCY	3,536,714		3,536,714	0	3,536,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,106,105		2,106,105		2,106,105	92.00
93.00	04950	BEHAVIOR HEALTH	614,335		614,335	0	614,335	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	32,619,267	0	32,619,267	0	32,619,267	200.00
201.00		Less Observation Beds	2,106,105		2,106,105		2,106,105	201.00
202.00		Total (see instructions)	30,513,162	0	30,513,162	0	30,513,162	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,551,602		4,551,602			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	200,438		200,438			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	637,779	5,521,806	6,159,585	0.387096	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,060	108,076	127,136	0.800599	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	146,435	518,689	665,124	0.036389	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,764	16,389,298	16,987,062	0.109684	0.000000	54.00
54.01	05401	ULTRASOUND	158,154	3,492,473	3,650,627	0.085898	0.000000	54.01
56.00	05600	RADIOISOTOPE	7,920	538,943	546,863	0.289414	0.000000	56.00
60.00	06000	LABORATORY	1,164,304	17,704,867	18,869,171	0.191848	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	288,108	559,305	847,413	0.013443	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	7,425	1,141,158	1,148,583	0.020787	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	538,147	1,931,980	2,470,127	0.397016	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	132,894	2,073,074	2,205,968	0.637196	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,902	614,097	644,999	0.453661	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,146	126,704	132,850	1.002725	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,804	31,104	37,908	0.303630	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	208,912	208,912	0.722285	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,033,853	4,013,567	6,047,420	0.194492	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	80,045	653,184	733,229	0.261827	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,392,151	4,458,644	5,850,795	0.329652	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,052,737	3,052,737	0.748446	0.000000	88.00
90.00	09000	CLINIC	0	495,732	495,732	0.410177	0.000000	90.00
90.01	09001	JV CLINIC	0	4,839,251	4,839,251	0.232787	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0	1,378,764	1,378,764	0.615549	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0	815,583	815,583	0.599547	0.000000	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	392,117	392,117	0.403359	0.000000	90.04
90.05	09005	ORTHO CLINIC	0	600,997	600,997	0.279133	0.000000	90.05
91.00	09100	EMERGENCY	358,319	9,829,139	10,187,458	0.347164	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	80,568	2,460,646	2,541,214	0.828779	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	4,080	663,817	667,897	0.919805	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	12,442,898	84,614,664	97,057,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,442,898	84,614,664	97,057,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	CARDIOPULMONARY	0.000000		70.01
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
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	JV CLINIC	0.000000		90.01
90.02	09002	CLINIC - LAKESIDE	0.000000		90.02
90.03	09003	CLINIC - QUICKCARE	0.000000		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.000000		90.04
90.05	09005	ORTHO CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	BEHAVIOR HEALTH	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	342,853	6,159,585	0.055662	160,235	8,919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,796	127,136	0.077051	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,060	665,124	0.012118	32,061	389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,763	16,987,062	0.009640	261,852	2,524	54.00
54.01	05401	ULTRASOUND	9,017	3,650,627	0.002470	87,508	216	54.01
56.00	05600	RADIOISOTOPE	7,596	546,863	0.013890	3,076	43	56.00
60.00	06000	LABORATORY	91,042	18,869,171	0.004825	572,500	2,762	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,654	847,413	0.003132	127,792	400	63.00
64.00	06400	INTRAVENOUS THERAPY	5,641	1,148,583	0.004911	1,520	7	64.00
65.00	06500	RESPIRATORY THERAPY	42,109	2,470,127	0.017047	266,128	4,537	65.00
66.00	06600	PHYSICAL THERAPY	97,755	2,205,968	0.044314	41,298	1,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,886	644,999	0.009126	3,628	33	67.00
68.00	06800	SPEECH PATHOLOGY	3,963	132,850	0.029831	4,531	135	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,177	37,908	0.083808	4,148	348	70.00
70.01	07001	CARDIOPULMONARY	23,147	208,912	0.110798	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,378	6,047,420	0.004527	564,252	2,554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,030	733,229	0.006860	37,641	258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,322	5,850,795	0.007575	645,139	4,887	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	75,075	3,052,737	0.024593	0	0	88.00
90.00	09000	CLINIC	9,826	495,732	0.019821	0	0	90.00
90.01	09001	JV CLINIC	65,228	4,839,251	0.013479	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	96,622	1,378,764	0.070079	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	66,848	815,583	0.081963	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	9,029	392,117	0.023026	0	0	90.04
90.05	09005	ORTHO CLINIC	5,798	600,997	0.009647	0	0	90.05
91.00	09100	EMERGENCY	158,414	10,187,458	0.015550	15,749	245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	144,647	2,541,214	0.056920	3,749	213	92.00
93.00	04950	BEHAVIOR HEALTH	59,820	667,897	0.089565	0	0	93.00
200.00		Total (lines 50 through 199)	1,584,496	92,305,522		2,832,807	30,300	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	JV CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0	0	0	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	0	0	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	0	0	0	90.04
90.05	09005	ORTHO CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04950	BEHAVIOR HEALTH	0	0	0	0	0	93.00
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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,159,585	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	127,136	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	665,124	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,987,062	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,650,627	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	546,863	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	18,869,171	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	847,413	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,148,583	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,470,127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,205,968	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	644,999	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	132,850	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	37,908	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	208,912	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,047,420	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	733,229	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,850,795	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,052,737	0.000000	88.00
90.00	09000	CLINIC	0	0	0	495,732	0.000000	90.00
90.01	09001	JV CLINIC	0	0	0	4,839,251	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0	0	0	1,378,764	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0	0	0	815,583	0.000000	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0	0	392,117	0.000000	90.04
90.05	09005	ORTHO CLINIC	0	0	0	600,997	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	10,187,458	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,541,214	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	0	0	0	667,897	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	92,305,522		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	160,235	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	32,061	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	261,852	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	87,508	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	3,076	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	572,500	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	127,792	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,520	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	266,128	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,298	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,628	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,531	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,148	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	564,252	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	37,641	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	645,139	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	JV CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.000000	0	0	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.000000	0	0	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	ORTHO CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	15,749	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,749	0	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		2,832,807	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.387096	0	1,587,041	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.800599	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.036389	0	224,445	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109684	0	4,703,983	0	0	54.00
54.01	05401	ULTRASOUND	0.085898	0	757,142	0	0	54.01
56.00	05600	RADIOISOTOPE	0.289414	0	198,494	0	0	56.00
60.00	06000	LABORATORY	0.191848	0	5,249,105	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.013443	0	189,595	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.020787	0	610,198	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.397016	0	583,130	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.637196	0	693,185	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453661	0	184,112	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.002725	0	5,183	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.303630	0	5,832	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.722285	0	157,417	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.194492	0	1,141,181	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.261827	0	146,251	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329652	0	1,767,781	44,432	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.410177	0	274,002	0	0	90.00
90.01	09001	JV CLINIC	0.232787	0	1,695,542	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.615549	0	64,983	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.599547	0	24,779	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.403359	0	15,648	0	0	90.04
90.05	09005	ORTHO CLINIC	0.279133	0	214,077	0	0	90.05
91.00	09100	EMERGENCY	0.347164	0	2,667,246	10,509	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	0	846,868	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.919805	0	464,436	0	0	93.00
200.00		Subtotal (see instructions)		0	24,471,656	54,941	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	24,471,656	54,941	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	614,337	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	8,167	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	515,952	0		54.00
54.01	05401	ULTRASOUND	65,037	0		54.01
56.00	05600	RADIOISOTOPE	57,447	0		56.00
60.00	06000	LABORATORY	1,007,030	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,549	0		63.00
64.00	06400	INTRAVENOUS THERAPY	12,684	0		64.00
65.00	06500	RESPIRATORY THERAPY	231,512	0		65.00
66.00	06600	PHYSICAL THERAPY	441,695	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	83,524	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,197	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,771	0		70.00
70.01	07001	CARDIOPULMONARY	113,700	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	221,951	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	38,292	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	582,753	14,647		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	112,389	0		90.00
90.01	09001	JV CLINIC	394,700	0		90.01
90.02	09002	CLINIC - LAKESIDE	40,000	0		90.02
90.03	09003	CLINIC - QUICKCARE	14,856	0		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	6,312	0		90.04
90.05	09005	ORTHO CLINIC	59,756	0		90.05
91.00	09100	EMERGENCY	925,972	3,648		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	701,866	0		92.00
93.00	04950	BEHAVIOR HEALTH	427,191	0		93.00
200.00		Subtotal (see instructions)	6,686,640	18,295		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,686,640	18,295		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.387096	0	120,173	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.800599	0	2,270	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.036389	0	43,707	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109684	0	607,995	0	0	54.00
54.01	05401	ULTRASOUND	0.085898	0	90,317	0	0	54.01
56.00	05600	RADIOISOTOPE	0.289414	0	4,326	0	0	56.00
60.00	06000	LABORATORY	0.191848	0	538,877	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.013443	0	13,263	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.020787	0	32,493	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.397016	0	35,101	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.637196	0	20,843	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453661	0	12,157	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.002725	0	10,890	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.303630	0	972	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.722285	0	7,854	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.194492	0	139,220	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.261827	0	72	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329652	0	77,829	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.410177	0	1,417	0	0	90.00
90.01	09001	JV CLINIC	0.232787	0	23,735	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.615549	0	0	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.599547	0	0	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.403359	0	0	0	0	90.04
90.05	09005	ORTHO CLINIC	0.279133	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.347164	0	690,235	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	0	84,757	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.919805	0	912	0	0	93.00
200.00		Subtotal (see instructions)		0	2,559,415	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,559,415	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	46,518	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,817	0		52.00
53.00	05300	ANESTHESIOLOGY	1,590	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,687	0		54.00
54.01	05401	ULTRASOUND	7,758	0		54.01
56.00	05600	RADIOISOTOPE	1,252	0		56.00
60.00	06000	LABORATORY	103,382	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	178	0		63.00
64.00	06400	INTRAVENOUS THERAPY	675	0		64.00
65.00	06500	RESPIRATORY THERAPY	13,936	0		65.00
66.00	06600	PHYSICAL THERAPY	13,281	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,515	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,920	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	295	0		70.00
70.01	07001	CARDIOPULMONARY	5,673	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,077	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,656	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	581	0		90.00
90.01	09001	JV CLINIC	5,525	0		90.01
90.02	09002	CLINIC - LAKESIDE	0	0		90.02
90.03	09003	CLINIC - QUICKCARE	0	0		90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0	0		90.04
90.05	09005	ORTHO CLINIC	0	0		90.05
91.00	09100	EMERGENCY	239,625	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	70,245	0		92.00
93.00	04950	BEHAVIOR HEALTH	839	0		93.00
200.00		Subtotal (see instructions)	649,044	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	649,044	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,413	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,064	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)	1,894	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	349	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)	1,014	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)	297	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	199.09	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)	6,143,703	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)	628,231	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,515,472	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,515,472	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)	1,800.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,825,291	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,825,291	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	692,166	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,517,457	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)	534,627	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)	534,627	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)	1,170	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,800.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,106,105	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	421,947	6,143,703	0.068680	2,106,105	144,647	90.00
91.00	Nursing School cost	0	6,143,703	0.000000	2,106,105	0	91.00
92.00	Allied health cost	0	6,143,703	0.000000	2,106,105	0	92.00
93.00	All other Medical Education	0	6,143,703	0.000000	2,106,105	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,413	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,064	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)	1,894	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	349	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)	53	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)	206	15.00
16.00	Nursery days (title V or XIX only)	12	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	199.09	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)	6,143,703	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)	628,231	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,515,472	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,515,472	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)	1,800.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	95,405	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)	95,405	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	168,038	206	815.72	12	9,789	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	72,962	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	178,156	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)	1,170	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,800.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,106,105	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	421,947	6,143,703	0.068680	2,106,105	144,647	90.00
91.00	Nursing School cost	0	6,143,703	0.000000	2,106,105	0	91.00
92.00	Allied health cost	0	6,143,703	0.000000	2,106,105	0	92.00
93.00	All other Medical Education	0	6,143,703	0.000000	2,106,105	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,335,202		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.387096	160,235	62,026	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.800599	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.036389	32,061	1,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109684	261,852	28,721	54.00
54.01	05401	ULTRASOUND	0.085898	87,508	7,517	54.01
56.00	05600	RADIOISOTOPE	0.289414	3,076	890	56.00
60.00	06000	LABORATORY	0.191848	572,500	109,833	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.013443	127,792	1,718	63.00
64.00	06400	INTRAVENOUS THERAPY	0.020787	1,520	32	64.00
65.00	06500	RESPIRATORY THERAPY	0.397016	266,128	105,657	65.00
66.00	06600	PHYSICAL THERAPY	0.637196	41,298	26,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453661	3,628	1,646	67.00
68.00	06800	SPEECH PATHOLOGY	1.002725	4,531	4,543	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.303630	4,148	1,259	70.00
70.01	07001	CARDIOPULMONARY	0.722285	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.194492	564,252	109,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.261827	37,641	9,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329652	645,139	212,671	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.410177	0	0	90.00
90.01	09001	JV CLINIC	0.232787	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.615549	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.599547	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.403359	0	0	90.04
90.05	09005	ORTHO CLINIC	0.279133	0	0	90.05
91.00	09100	EMERGENCY	0.347164	15,749	5,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	3,749	3,107	92.00
93.00	04950	BEHAVIOR HEALTH	0.919805	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,832,807	692,166	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,832,807		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		270,619		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.387096	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.800599	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.036389	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109684	3,688	405	54.00
54.01	05401	ULTRASOUND	0.085898	0	0	54.01
56.00	05600	RADIOISOTOPE	0.289414	0	0	56.00
60.00	06000	LABORATORY	0.191848	56,209	10,784	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.013443	3,053	41	63.00
64.00	06400	INTRAVENOUS THERAPY	0.020787	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.397016	44,584	17,701	65.00
66.00	06600	PHYSICAL THERAPY	0.637196	56,239	35,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453661	19,726	8,949	67.00
68.00	06800	SPEECH PATHOLOGY	1.002725	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.303630	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.722285	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.194492	47,732	9,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.261827	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329652	74,851	24,675	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.410177	0	0	90.00
90.01	09001	JV CLINIC	0.232787	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.615549	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.599547	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.403359	0	0	90.04
90.05	09005	ORTHO CLINIC	0.279133	0	0	90.05
91.00	09100	EMERGENCY	0.347164	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.919805	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		306,082	107,673	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)		306,082		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/11/2021 9:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		118,173		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		36,974		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.387096	17,157	6,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.800599	696	557	52.00
53.00	05300	ANESTHESIOLOGY	0.036389	29,776	1,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109684	29,908	3,280	54.00
54.01	05401	ULTRASOUND	0.085898	4,213	362	54.01
56.00	05600	RADIOISOTOPE	0.289414	0	0	56.00
60.00	06000	LABORATORY	0.191848	34,498	6,618	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.013443	12,457	167	63.00
64.00	06400	INTRAVENOUS THERAPY	0.020787	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.397016	13,810	5,483	65.00
66.00	06600	PHYSICAL THERAPY	0.637196	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453661	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.002725	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.303630	972	295	70.00
70.01	07001	CARDIOPULMONARY	0.722285	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.194492	98,415	19,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.261827	3,621	948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329652	36,349	11,983	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.748446	0	0	88.00
90.00	09000	CLINIC	0.410177	0	0	90.00
90.01	09001	JV CLINIC	0.232787	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.615549	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.599547	0	0	90.03
90.04	09004	WOMEN'S HEALTH CLINIC	0.403359	0	0	90.04
90.05	09005	ORTHO CLINIC	0.279133	0	0	90.05
91.00	09100	EMERGENCY	0.347164	17,237	5,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	12,072	10,005	92.00
93.00	04950	BEHAVIOR HEALTH	0.919805	450	414	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		311,631	72,962	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)		311,631		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 6/11/2021 9:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,704,935	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,704,935	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,771,984	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	87,082	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,787,020	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,897,882	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,897,882	30.00
31.00	Primary payer payments	3,737	31.00
32.00	Subtotal (line 30 minus line 31)	2,894,145	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)	965,575	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	627,624	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	744,262	36.00
37.00	Subtotal (see instructions)	3,521,769	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,521,769	40.00
40.01	Sequestration adjustment (see instructions)	23,244	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,576,160	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-77,635	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Hospital | Cost

		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		1,930,313		3,576,160	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,930,313		3,576,160	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		375,014		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		77,635	6.02
7.00	Total Medicare program liability (see instructions)		2,305,327		3,498,525	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Swing Beds - SNF | Cost

		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		489,863		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		489,863		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		148,809		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		638,672		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 6/11/2021 9:17 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | Swing Beds - SNF | Cost

		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)	539,973	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			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)	108,750	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	297	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)	648,723	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	648,723	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	648,723	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,808	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	642,915	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	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)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	642,915	0	19.00
19.01	Sequestration adjustment (see instructions)	4,243	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	489,863	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	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)	148,809	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	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
	Comparision 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: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 6/11/2021 9:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,517,457	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,517,457	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,542,632	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,542,632	19.00
20.00	Deductibles (exclude professional component)	256,168	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,286,464	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,286,464	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52,583	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	34,179	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,326	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,320,643	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,320,643	30.00
30.01	Sequestration adjustment (see instructions)	15,316	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,930,313	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	375,014	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 6/11/2021 9:17 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	178,156		1.00
2.00	Medical and other services		649,044	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	178,156	649,044	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)	178,156	649,044	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	311,631	2,559,415	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)	311,631	2,559,415	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)	311,631	2,559,415	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	133,475	1,910,371	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)	178,156	649,044	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)	178,156	649,044	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)	178,156	649,044	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	178,156	649,044	36.00
37.00	OTHER ADJUSTMENT	-178,156	-649,044	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 6/11/2021 9:17 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,290,118	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	11,531,325	0	0	0	4.00
5.00	Other receivable	-2,594,699	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,131,419	0	0	0	6.00
7.00	Inventory	624,689	0	0	0	7.00
8.00	Prepaid expenses	950,154	0	0	0	8.00
9.00	Other current assets	382,121	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)	16,052,289	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,036,127	0	0	0	12.00
13.00	Land improvements	3,096,707	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,596,347	0	0	0	15.00
16.00	Accumulated depreciation	-27,749,406	0	0	0	16.00
17.00	Leasehold improvements	320	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,626,644	0	0	0	19.00
20.00	Accumulated depreciation	-583,722	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,792,469	0	0	0	23.00
24.00	Accumulated depreciation	-2,939,799	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)	16,875,687	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	9,232,198	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,232,198	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,160,174	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,772,990	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,271,555	0	0	0	38.00
39.00	Payroll taxes payable	3,093	0	0	0	39.00
40.00	Notes and loans payable (short term)	584,278	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-493,433	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,138,483	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,453,621	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,453,621	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,592,104	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,568,070				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)	29,568,070	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,160,174	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 6/11/2021 9:17 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		26,382,076		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,185,994				2.00
3.00	Total (sum of line 1 and line 2)		29,568,070		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)		29,568,070		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)		29,568,070		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: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/11/2021 9:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,434,679		5,434,679	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)	5,434,679		5,434,679	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,434,679		5,434,679	17.00
18.00	Ancillary services	8,268,514	63,153,694	71,422,208	18.00
19.00	Outpatient services	3,505,605	15,093,223	18,598,828	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUE	200,438	201,208	401,646	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,409,236	78,448,125	95,857,361	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,249,147		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)		35,249,147		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 6/11/2021 9:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	95,857,361	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,825,164	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,032,197	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,249,147	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,216,950	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	512,406	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	112,489	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	135,992	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	1,399,752	17.00
18.00	Revenue from sale of medical records and abstracts	3,373	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	199,274	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	389,658	24.00
24.50	COVID-19 PHE Funding	1,650,000	24.50
25.00	Total other income (sum of lines 6-24)	4,402,944	25.00
26.00	Total (line 5 plus line 25)	3,185,994	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)	3,185,994	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 9:17 am

RHC I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	490,609	0	490,609	0	490,609	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	247,625	0	247,625	0	247,625	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	222,687	0	222,687	-85,314	137,373	9.00
10.00	Subtotal (sum of lines 1 through 9)	960,921	0	960,921	-85,314	875,607	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	178,301	178,301	0	178,301	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	178,301	178,301	0	178,301	14.00
15.00	Medical Supplies	0	122,327	122,327	0	122,327	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	122,327	122,327	0	122,327	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	960,921	300,628	1,261,549	-85,314	1,176,235	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	1,271	1,271	0	1,271	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,271	1,271	0	1,271	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	230,646	230,646	0	230,646	29.00
30.00	Administrative Costs	0	9,440	9,440	85,314	94,754	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	240,086	240,086	85,314	325,400	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	960,921	541,985	1,502,906	0	1,502,906	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 9:17 am

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	490,609		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	247,625		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	137,373		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	875,607		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	178,301		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	178,301		14.00
15.00	Medical Supplies	-102,483	19,844		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-102,483	19,844		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-102,483	1,073,752		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	-1,271	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-1,271	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-80	230,566		29.00
30.00	Administrative Costs	0	94,754		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-80	325,320		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-103,834	1,399,072		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 6/11/2021 9:17 am

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.49	5,569	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.58	7,270	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.07	12,839		3	12,839	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.07	12,839			12,839	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,073,752	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,073,752	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	325,320	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	885,738	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,211,058	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,211,058	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,211,058	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,284,810	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1327 Component CCN: 15-8540	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 6/11/2021 9:17 am
	Title XVIII	RHC I	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,284,810	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		105,987	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,178,823	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,839	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		12,839	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		169.70	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)	169.70	169.70	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,110	1,109	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	188,367	188,197	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	3	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	509	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	509	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	377,073	16.00
16.01	Total program charges (see instructions)(from contractor's records)		403,285	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,431	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,338	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		252,462	16.04
16.05	Total program cost (see instructions)	0	253,800	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		60,157	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		68,231	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		253,800	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		36,180	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		289,980	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		289,980	26.00
26.01	Sequestration adjustment (see instructions)		1,914	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		281,201	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		6,865	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-4 | Date/Time Prepared: 6/11/2021 9:17 am

Title XVIII | RHC I

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	875,607	875,607	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001005	0.003478	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	880	3,045	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	26,721	19,163	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	27,601	22,208	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,073,752	1,073,752	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,211,058	1,211,058	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.025705	0.020683	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	31,130	25,048	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	58,731	47,256	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	180	623	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	326.28	75.85	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	53	249	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	17,293	18,887	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		105,987	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		36,180	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1327 Component CCN: 15-8540	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 6/11/2021 9:17 am

RHC I

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		247,201	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		06/17/2020	34,000	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		34,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		281,201	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		6,865	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		288,066	7.00

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