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: 15-2028	Period: From 11/01/2019 To 10/31/2020	Worksheet S Parts I-III Date/Time Prepared: 2/25/2021 9:51 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/25/2021 Time: 9:51 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 VIBRA HOSPITAL OF NORTHWEST INDIANA (15-2028) for the cost reporting period beginning 11/01/2019 and ending 10/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CLINT FEGAN
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-89,249	21	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	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-89,249	21	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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2021 9:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 9509 GEORGIA STREET	PO Box:			1.00
2.00	City: CROWN POINT	State: IN	Zip Code: 46307-6518	County: LAKE	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	VIBRA HOSPITAL OF NORTHWEST INDIANA	152028	23844	2	08/08/2008	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	11/01/2019	10/31/2020	20.00
21.00	Type of Control (see instructions)	6		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	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.	0	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2021 9:51 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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2021 9:51 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2021 9:51 am

		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-2028	Period: From 11/01/2019 To 10/31/2020	Worksheet S-2 Part I Date/Time Prepared: 2/25/2021 9:51 am

		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.	Y	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	N	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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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

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		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.	N			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.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
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	HB2280	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2021 9:51 am

	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: VIBRA MANAGEMENT LLC	Contractor's Name: CGS	Contractor's Number: 15101	141.00
142.00	Street: 4600 LENA DRIVE	PO Box:		142.00
143.00	City: MECHANICSBURG	State: PA	Zip Code: 17055	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.	Y		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.	N	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

		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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2021 9:51 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.	N			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	02/15/2021	Y	02/15/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2021 9:51 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KIMBERLY	ROSSEY	41.00
42.00	Enter the employer/company name of the cost report preparer.	VIBRA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-591-5794	KROSSEY@VIBRAHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-2028	Period: From 11/01/2019 To 10/31/2020	Worksheet S-2 Part II Date/Time Prepared: 2/25/2021 9:51 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 OF REIMBURSEMENT		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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2021 9:51 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	40	14,640	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,640	0.00	0	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)		40	14,640	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2021 9:51 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)	5,919	0	10,226			1.00
2.00	HMO and other (see instructions)	559	1,610				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,919	0	10,226			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)	5,919	0	10,226	0.00	106.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	106.09	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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	28					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2021 9:51 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	258	0	428	1.00
2.00	HMO and other (see instructions)			21	57		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	258	0	428	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			1			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2021 9:51 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	7,482,888	0	7,482,888	0.00	0.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		0	0	0			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 2/25/2021 9:51 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	80,214	0	80,214	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,489,695	0	1,489,695	0.00	0.00	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	181,638	0	181,638	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	125,826	0	125,826	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	296,140	0	296,140	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	266,534	0	266,534	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	467,133	0	467,133	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	128,800	0	128,800	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 2/25/2021 9:51 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		7,482,888	0	7,482,888	0.00	0.00	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		7,482,888	0	7,482,888	0.00	0.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		7,482,888	0	7,482,888	0.00	0.00	6.00
7.00	Total overhead cost (see instructions)		3,035,980	0	3,035,980	0.00	0.00	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 2/25/2021 9:51 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A | Date/Time Prepared: 2/25/2021 9:51 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	CAP REL COSTS-BLDG & FIXT		65,153	65,153	0	65,153	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		177,602	177,602	0	177,602	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	80,214	1,625,905	1,706,119	0	1,706,119	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,489,695	1,275,866	2,765,561	0	2,765,561	5.00
7.00	00700	OPERATION OF PLANT	181,638	303,109	484,747	0	484,747	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,533	101,533	0	101,533	8.00
9.00	00900	HOUSEKEEPING	125,826	39,249	165,075	0	165,075	9.00
10.00	01000	DIETARY	296,140	123,252	419,392	0	419,392	10.00
13.00	01300	NURSING ADMINISTRATION	266,534	1,242	267,776	0	267,776	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	636,931	636,931	0	636,931	14.00
15.00	01500	PHARMACY	467,133	20,206	487,339	0	487,339	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,800	67,724	196,524	0	196,524	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,735,151	1,044,694	4,779,845	0	4,779,845	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,708	104,708	0	104,708	54.00
60.00	06000	LABORATORY	0	271,772	271,772	0	271,772	60.00
65.00	06500	RESPIRATORY THERAPY	711,757	70,763	782,520	0	782,520	65.00
66.00	06600	PHYSICAL THERAPY	0	217,875	217,875	0	217,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	194,247	194,247	0	194,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	107,102	107,102	0	107,102	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	852,090	852,090	0	852,090	73.00
74.00	07400	RENAL DIALYSIS	0	405,374	405,374	0	405,374	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,482,888	7,706,397	15,189,285	0	15,189,285	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		TOTAL (SUM OF LINES 118 through 199)	7,482,888	7,706,397	15,189,285	0	15,189,285	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-7,518	57,635		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-310	177,292		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,706,119		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	667,292	3,432,853		5.00
7.00	00700	OPERATION OF PLANT	0	484,747		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,533		8.00
9.00	00900	HOUSEKEEPING	0	165,075		9.00
10.00	01000	DIETARY	0	419,392		10.00
13.00	01300	NURSING ADMINISTRATION	0	267,776		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	636,931		14.00
15.00	01500	PHARMACY	0	487,339		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-470	196,054		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-576,888	4,202,957		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,708		54.00
60.00	06000	LABORATORY	0	271,772		60.00
65.00	06500	RESPIRATORY THERAPY	0	782,520		65.00
66.00	06600	PHYSICAL THERAPY	0	217,875		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	194,247		67.00
68.00	06800	SPEECH PATHOLOGY	0	107,102		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	852,090		73.00
74.00	07400	RENAL DIALYSIS	0	405,374		74.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,106	15,271,391		118.00
		NONREIMBURSABLE COST CENTERS				
200.00		TOTAL (SUM OF LINES 118 through 199)	82,106	15,271,391		200.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2021 9:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	98,029	25,598	0	25,598	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	15,506	157,664	0	157,664	0	4.00
5.00	Fixed Equipment	98,413	0	0	0	97,463	5.00
6.00	Movable Equipment	584,608	67,510	0	67,510	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	796,556	250,772	0	250,772	97,463	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	796,556	250,772	0	250,772	97,463	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	123,627	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	173,170	0	4.00
5.00	Fixed Equipment	950	0	5.00
6.00	Movable Equipment	652,118	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	949,865	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	949,865	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 2/25/2021 9:51 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	CAP REL COSTS-BLDG & FIXT	0	-112,595	0	0	173,221	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	90,200	87,092	0	0	0	2.00
3.00	Total (sum of lines 1-2)	90,200	-25,503	0	0	173,221	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	4,527	65,153	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	310	177,602	2.00
3.00	Total (sum of lines 1-2)	4,837	242,755	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2021 9:51 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	297,747	0	297,747	0.313723	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	652,118	788	651,330	0.686277	0	2.00
3.00	Total (sum of lines 1-2)	949,865	788	949,077	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	-112,595	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	90,200	87,092	2.00
3.00	Total (sum of lines 1-2)	0	0	0	90,200	-25,503	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	173,221	-2,991	57,635	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	177,292	2.00
3.00	Total (sum of lines 1-2)	0	0	173,221	-2,991	234,927	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-8 | Date/Time Prepared: 2/25/2021 9:51 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-436,713			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	1,055,644			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-470	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)	B	-4,642	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER INCOME A&G	B	-19,052	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-8 | Date/Time Prepared: 2/25/2021 9:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	LEGAL FEES	A	-851	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	SPONSORSHIP	A	-7,500	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MARKETING NON-ALLOWABLE	A	-21,172	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	BAD DEBT EXPENSE	A	-334,694	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	AMBULANCE TRANSPORT	A	-140,175	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	GAIN (LOSS)-REFINANCE	A	-7,518	CAP REL COSTS-BLDG & FIXT	1.00	14	33.06
33.07	GAIN (LOSS) ASSET DSP	A	-310	CAP REL COSTS-MVBLE EQUIP	2.00	14	33.07
33.08	LOBBYING EXPENSE	A	-441	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		82,106				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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2021 9:51 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	5.00	ADMINISTRATIVE & GENERAL	CORPORATE EXPENSES	1,400,178	344,534	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,400,178	344,534	5.00

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

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

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

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

6.00	B	VIBRA MANAGEMENT LLC	100.00	VIBRA HEALTHCARE LLC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-2028	Period: From 11/01/2019 To 10/31/2020	Worksheet A-8-1 Date/Time Prepared: 2/25/2021 9:51 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	1,055,644	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	1,055,644			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	CORPORATE OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2021 9:51 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	AGGREGATE-ADULTS & PEDIATRICS	287,938	287,938	0	206,300	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	247,958	48,000	199,958	206,300	1,000	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		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			535,896	335,938	199,958		1,000	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	99,183	4,959	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		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			99,183	4,959	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	287,938		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	99,183	100,775	148,775		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		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	99,183	100,775	436,713		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part I Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	57,635	57,635				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	177,292		177,292			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,706,119	0	0	1,706,119		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,432,853	3,406	10,478	343,334	3,790,071	5.00
7.00	00700	OPERATION OF PLANT	484,747	21,400	65,828	41,863	613,838	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,533	753	2,317	0	104,603	8.00
9.00	00900	HOUSEKEEPING	165,075	407	1,253	28,999	195,734	9.00
10.00	01000	DIETARY	419,392	2,834	8,718	68,252	499,196	10.00
13.00	01300	NURSING ADMINISTRATION	267,776	0	0	61,429	329,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	636,931	0	0	0	636,931	14.00
15.00	01500	PHARMACY	487,339	938	2,885	107,662	598,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196,054	694	2,134	29,685	228,567	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,202,957	25,195	77,505	860,854	5,166,511	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,708	143	440	0	105,291	54.00
60.00	06000	LABORATORY	271,772	121	373	0	272,266	60.00
65.00	06500	RESPIRATORY THERAPY	782,520	76	232	164,041	946,869	65.00
66.00	06600	PHYSICAL THERAPY	217,875	578	1,779	0	220,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,247	690	2,121	0	197,058	67.00
68.00	06800	SPEECH PATHOLOGY	107,102	207	636	0	107,945	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	852,090	0	0	0	852,090	73.00
74.00	07400	RENAL DIALYSIS	405,374	193	593	0	406,160	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,271,391	57,635	177,292	1,706,119	15,271,391	118.00
		NONREIMBURSABLE COST CENTERS						
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)	15,271,391	57,635	177,292	1,706,119	15,271,391	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part I Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,790,071					5.00
7.00	00700	OPERATION OF PLANT	202,633	816,471				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,530	18,733	157,866			8.00
9.00	00900	HOUSEKEEPING	64,613	10,132	0	270,479		9.00
10.00	01000	DIETARY	164,789	70,482	0	24,205	758,672	10.00
13.00	01300	NURSING ADMINISTRATION	108,673	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	210,256	0	0	0	0	14.00
15.00	01500	PHARMACY	197,677	23,329	0	8,012	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,452	17,250	0	5,924	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,705,502	626,625	157,866	215,196	758,672	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,757	3,559	0	1,222	0	54.00
60.00	06000	LABORATORY	89,877	3,015	0	1,035	0	60.00
65.00	06500	RESPIRATORY THERAPY	312,569	1,878	0	645	0	65.00
66.00	06600	PHYSICAL THERAPY	72,700	14,383	0	4,939	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,050	17,151	0	5,890	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,634	5,140	0	1,765	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,282	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	134,077	4,794	0	1,646	0	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,790,071	816,471	157,866	270,479	758,672	118.00
		NONREIMBURSABLE COST CENTERS						
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)	3,790,071	816,471	157,866	270,479	758,672	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part I Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	437,878					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	847,187				14.00
15.00	01500	PHARMACY	0	0	827,842			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	327,193		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	437,878	847,187	0	327,193	10,242,630	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	144,829	54.00
60.00	06000	LABORATORY	0	0	0	0	366,193	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,261,961	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	312,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	285,149	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	150,484	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	827,842	0	1,961,214	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	546,677	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	437,878	847,187	827,842	327,193	15,271,391	118.00
		NONREIMBURSABLE COST CENTERS						
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)	437,878	847,187	827,842	327,193	15,271,391	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part I | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	10,242,630		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,829		54.00
60.00	06000	LABORATORY	0	366,193		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,261,961		65.00
66.00	06600	PHYSICAL THERAPY	0	312,254		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	285,149		67.00
68.00	06800	SPEECH PATHOLOGY	0	150,484		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,961,214		73.00
74.00	07400	RENAL DIALYSIS	0	546,677		74.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,271,391		118.00
		NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	15,271,391		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part II Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	3,406	10,478	13,884	0	5.00
7.00	00700	OPERATION OF PLANT	0	21,400	65,828	87,228	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	753	2,317	3,070	0	8.00
9.00	00900	HOUSEKEEPING	0	407	1,253	1,660	0	9.00
10.00	01000	DIETARY	0	2,834	8,718	11,552	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	938	2,885	3,823	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	694	2,134	2,828	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,195	77,505	102,700	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	143	440	583	0	54.00
60.00	06000	LABORATORY	0	121	373	494	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	76	232	308	0	65.00
66.00	06600	PHYSICAL THERAPY	0	578	1,779	2,357	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	690	2,121	2,811	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	207	636	843	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	193	593	786	0	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	57,635	177,292	234,927	0	118.00
		NONREIMBURSABLE COST CENTERS						
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	57,635	177,292	234,927	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part II | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,884					5.00
7.00	00700	OPERATION OF PLANT	742	87,970				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	126	2,018	5,214			8.00
9.00	00900	HOUSEKEEPING	237	1,092	0	2,989		9.00
10.00	01000	DIETARY	604	7,594	0	267	20,017	10.00
13.00	01300	NURSING ADMINISTRATION	398	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	770	0	0	0	0	14.00
15.00	01500	PHARMACY	724	2,514	0	89	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	276	1,859	0	65	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,250	67,514	5,214	2,378	20,017	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	127	383	0	14	0	54.00
60.00	06000	LABORATORY	329	325	0	11	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,145	202	0	7	0	65.00
66.00	06600	PHYSICAL THERAPY	266	1,550	0	55	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	238	1,848	0	65	0	67.00
68.00	06800	SPEECH PATHOLOGY	131	554	0	20	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	491	517	0	18	0	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,884	87,970	5,214	2,989	20,017	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,884	87,970	5,214	2,989	20,017	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part II Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	398					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	770				14.00
15.00	01500	PHARMACY	0	0	7,150			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,028		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	398	770	0	5,028	210,269	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,107	54.00
60.00	06000	LABORATORY	0	0	0	0	1,159	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,662	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	4,228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,962	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,548	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,150	0	8,180	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,812	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398	770	7,150	5,028	234,927	118.00
		NONREIMBURSABLE COST CENTERS						
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)	398	770	7,150	5,028	234,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B Part II | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	210,269		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,107		54.00
60.00	06000	LABORATORY	0	1,159		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,662		65.00
66.00	06600	PHYSICAL THERAPY	0	4,228		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,962		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,548		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,180		73.00
74.00	07400	RENAL DIALYSIS	0	1,812		74.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	234,927		118.00
		NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	234,927		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B-1 | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	29,001					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		29,001				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,402,674			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,714	1,714	1,489,695	-3,790,071	11,481,320	5.00
7.00	00700	OPERATION OF PLANT	10,768	10,768	181,638	0	613,838	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	379	379	0	0	104,603	8.00
9.00	00900	HOUSEKEEPING	205	205	125,826	0	195,734	9.00
10.00	01000	DIETARY	1,426	1,426	296,140	0	499,196	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	266,534	0	329,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	636,931	14.00
15.00	01500	PHARMACY	472	472	467,133	0	598,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	349	349	128,800	0	228,567	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,678	12,678	3,735,151	0	5,166,511	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	72	72	0	0	105,291	54.00
60.00	06000	LABORATORY	61	61	0	0	272,266	60.00
65.00	06500	RESPIRATORY THERAPY	38	38	711,757	0	946,869	65.00
66.00	06600	PHYSICAL THERAPY	291	291	0	0	220,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	347	347	0	0	197,058	67.00
68.00	06800	SPEECH PATHOLOGY	104	104	0	0	107,945	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	852,090	73.00
74.00	07400	RENAL DIALYSIS	97	97	0	0	406,160	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,001	29,001	7,402,674	-3,790,071	11,481,320	118.00
		NONREIMBURSABLE COST CENTERS						
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)	57,635	177,292	1,706,119		3,790,071	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.987345	6.113306	0.230473		0.330108	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		13,884	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.001209	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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B-1 | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (NURSING FTE'S)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	16,519					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	379	10,226				8.00
9.00	00900	HOUSEKEEPING	205	0	15,935			9.00
10.00	01000	DIETARY	1,426	0	1,426	10,226		10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	40	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	472	0	472	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	349	0	349	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,678	10,226	12,678	10,226	40	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	72	0	72	0	0	54.00
60.00	06000	LABORATORY	61	0	61	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	38	0	38	0	0	65.00
66.00	06600	PHYSICAL THERAPY	291	0	291	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	347	0	347	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	104	0	104	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	97	0	97	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,519	10,226	15,935	10,226	40	118.00
		NONREIMBURSABLE COST CENTERS						
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)	816,471	157,866	270,479	758,672	437,878	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.426176	15.437708	16.973894	74.190495	10,946.950000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,970	5,214	2,989	20,017	398	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.325383	0.509877	0.187575	1.957461	9.950000	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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet B-1 | Date/Time Prepared: 2/25/2021 9:51 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	422,584				14.00
15.00	01500	PHARMACY	0	852,090			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,226		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	422,584	0	10,226		30.00
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	852,090	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	422,584	852,090	10,226		118.00
		NONREIMBURSABLE COST CENTERS					
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)	847,187	827,842	327,193		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.004778	0.971543	31.996186		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	770	7,150	5,028		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001822	0.008391	0.491688		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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part I Date/Time Prepared: 2/25/2021 9:51 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,242,630		10,242,630	100,775	10,343,405	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,829		144,829	0	144,829	54.00
60.00	06000	LABORATORY	366,193		366,193	0	366,193	60.00
65.00	06500	RESPIRATORY THERAPY	1,261,961	0	1,261,961	0	1,261,961	65.00
66.00	06600	PHYSICAL THERAPY	312,254	0	312,254	0	312,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,149	0	285,149	0	285,149	67.00
68.00	06800	SPEECH PATHOLOGY	150,484	0	150,484	0	150,484	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,961,214		1,961,214	0	1,961,214	73.00
74.00	07400	RENAL DIALYSIS	546,677		546,677	0	546,677	74.00
200.00		Subtotal (see instructions)	15,271,391	0	15,271,391	100,775	15,372,166	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,271,391	0	15,271,391	100,775	15,372,166	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part I Date/Time Prepared: 2/25/2021 9:51 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,521,235		47,521,235			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	889,666	484	890,150	0.162702	0.000000	54.00
60.00	06000	LABORATORY	2,859,496	0	2,859,496	0.128062	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,890,378	0	7,890,378	0.159937	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	697,570	0	697,570	0.447631	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	626,333	0	626,333	0.455267	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	347,407	0	347,407	0.433163	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,579,515	0	10,579,515	0.185378	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,185,714	15,507	3,201,221	0.170771	0.000000	74.00
200.00		Subtotal (see instructions)	74,597,314	15,991	74,613,305			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,597,314	15,991	74,613,305			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part I Date/Time Prepared: 2/25/2021 9:51 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162702		54.00
60.00	06000	LABORATORY	0.128062		60.00
65.00	06500	RESPIRATORY THERAPY	0.159937		65.00
66.00	06600	PHYSICAL THERAPY	0.447631		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455267		67.00
68.00	06800	SPEECH PATHOLOGY	0.433163		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.185378		73.00
74.00	07400	RENAL DIALYSIS	0.170771		74.00
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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part I Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,242,630		10,242,630	100,775	10,343,405	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,829		144,829	0	144,829	54.00
60.00	06000	LABORATORY	366,193		366,193	0	366,193	60.00
65.00	06500	RESPIRATORY THERAPY	1,261,961	0	1,261,961	0	1,261,961	65.00
66.00	06600	PHYSICAL THERAPY	312,254	0	312,254	0	312,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,149	0	285,149	0	285,149	67.00
68.00	06800	SPEECH PATHOLOGY	150,484	0	150,484	0	150,484	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,961,214		1,961,214	0	1,961,214	73.00
74.00	07400	RENAL DIALYSIS	546,677		546,677	0	546,677	74.00
200.00		Subtotal (see instructions)	15,271,391	0	15,271,391	100,775	15,372,166	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,271,391	0	15,271,391	100,775	15,372,166	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part I Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		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	0		0			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part I Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part II | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,829	1,107	143,722	0	0	54.00
60.00	06000	LABORATORY	366,193	1,159	365,034	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,261,961	1,662	1,260,299	0	0	65.00
66.00	06600	PHYSICAL THERAPY	312,254	4,228	308,026	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,149	4,962	280,187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	150,484	1,548	148,936	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,961,214	8,180	1,953,034	0	0	73.00
74.00	07400	RENAL DIALYSIS	546,677	1,812	544,865	0	0	74.00
200.00		Subtotal (sum of lines 50 thru 199)	5,028,761	24,658	5,004,103	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	5,028,761	24,658	5,004,103	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet C Part II | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,829	890,150	0.162702		54.00
60.00	06000	LABORATORY	366,193	2,859,496	0.128062		60.00
65.00	06500	RESPIRATORY THERAPY	1,261,961	7,890,378	0.159937		65.00
66.00	06600	PHYSICAL THERAPY	312,254	697,570	0.447631		66.00
67.00	06700	OCCUPATIONAL THERAPY	285,149	626,333	0.455267		67.00
68.00	06800	SPEECH PATHOLOGY	150,484	347,407	0.433163		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,961,214	10,579,515	0.185378		73.00
74.00	07400	RENAL DIALYSIS	546,677	3,201,221	0.170771		74.00
200.00		Subtotal (sum of lines 50 thru 199)	5,028,761	27,092,070			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	5,028,761	27,092,070			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part I Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	210,269	0	210,269	10,226	20.56	30.00
200.00	Total (lines 30 through 199)	210,269		210,269	10,226		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,919	121,695	30.00
200.00	Total (lines 30 through 199)	5,919	121,695	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part II Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107	890,150	0.001244	521,076	648	54.00
60.00	06000	LABORATORY	1,159	2,859,496	0.000405	1,865,351	755	60.00
65.00	06500	RESPIRATORY THERAPY	1,662	7,890,378	0.000211	4,489,642	947	65.00
66.00	06600	PHYSICAL THERAPY	4,228	697,570	0.006061	410,109	2,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,962	626,333	0.007922	373,482	2,959	67.00
68.00	06800	SPEECH PATHOLOGY	1,548	347,407	0.004456	207,163	923	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,180	10,579,515	0.000773	5,791,947	4,477	73.00
74.00	07400	RENAL DIALYSIS	1,812	3,201,221	0.000566	1,868,994	1,058	74.00
200.00		Total (lines 50 through 199)	24,658	27,092,070		15,527,764	14,253	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part III Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,226	0.00	5,919	30.00
200.00		Total (lines 30 through 199)		0	10,226		5,919	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part IV | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part IV Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	890,150	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	2,859,496	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,890,378	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	697,570	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	626,333	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	347,407	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,579,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,201,221	0.000000	74.00
200.00		Total (lines 50 through 199)	0	0	0	27,092,070		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part IV | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	521,076	0	484	0	54.00
60.00	06000	LABORATORY	0.000000	1,865,351	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,489,642	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	410,109	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	373,482	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	207,163	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,791,947	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,868,994	0	15,507	0	74.00
200.00		Total (lines 50 through 199)		15,527,764	0	15,991	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part V Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162702	484	0	0	79	54.00
60.00	06000	LABORATORY	0.128062	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.159937	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.447631	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455267	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.433163	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.185378	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.170771	15,507	0	0	2,648	74.00
200.00		Subtotal (see instructions)		15,991	0	0	2,727	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		15,991	0	0	2,727	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part V Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part I Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	210,269	0	210,269	10,226	20.56	30.00
200.00	Total (lines 30 through 199)	210,269		210,269	10,226		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
200.00	Total (lines 30 through 199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part II Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	1,159	0	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,662	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,228	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,962	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,548	0	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,180	0	0.000000	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,812	0	0.000000	0	0	74.00
200.00		Total (lines 50 through 199)	24,658	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part III Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,226	0.00	0	30.00
200.00		Total (lines 30 through 199)		0	10,226		0	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part IV | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part IV | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D Part IV | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-1 | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,226	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,226	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)	10,226	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,919	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,343,405	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,343,405	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,343,405	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)	1,011.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,986,950	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)	5,986,950	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-1 | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,877,938	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,864,888	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)	121,695	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,253	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	135,948	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,728,940	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-1 | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	210,269	10,343,405	0.020329	0	0	90.00
91.00	Nursing School cost	0	10,343,405	0.000000	0	0	91.00
92.00	Allied health cost	0	10,343,405	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,343,405	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-1 | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,226	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,226	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)	10,226	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,343,405	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,343,405	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,343,405	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)	1,011.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-1 | Date/Time Prepared: 2/25/2021 9:51 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-1 | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	210,269	10,343,405	0.020329	0	0	90.00
91.00	Nursing School cost	0	10,343,405	0.000000	0	0	91.00
92.00	Allied health cost	0	10,343,405	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,343,405	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-3 | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		28,822,592		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162702	521,076	84,780	54.00
60.00	06000	LABORATORY	0.128062	1,865,351	238,881	60.00
65.00	06500	RESPIRATORY THERAPY	0.159937	4,489,642	718,060	65.00
66.00	06600	PHYSICAL THERAPY	0.447631	410,109	183,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455267	373,482	170,034	67.00
68.00	06800	SPEECH PATHOLOGY	0.433163	207,163	89,735	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.185378	5,791,947	1,073,700	73.00
74.00	07400	RENAL DIALYSIS	0.170771	1,868,994	319,170	74.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,527,764	2,877,938	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)		15,527,764		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet D-3 | Date/Time Prepared: 2/25/2021 9:51 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2028	Period: From 11/01/2019 To 10/31/2020	Worksheet E Part B Date/Time Prepared: 2/25/2021 9:51 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,727	2.00
3.00	OPPS payments	2,437	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)	0	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)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2,437	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	487	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)	1,950	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)	1,950	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,950	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,950	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)	1,950	40.00
40.01	Sequestration adjustment (see instructions)	19	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	1,910	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)	21	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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2021 9:51 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,633,125		1,910	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)		9,633,125		1,910	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		21	6.01
6.02	SETTLEMENT TO PROGRAM		89,249		0	6.02
7.00	Total Medicare program liability (see instructions)		9,543,876		1,931	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	Provider CCN: 15-2028	Period: From 11/01/2019 To 10/31/2020	Worksheet E-3 Part IV Date/Time Prepared: 2/25/2021 9:51 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	9,678,272	1.00
1.01	Full standard payment amount	7,668,788	1.01
1.02	Short stay outlier standard payment amount	2,001,707	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	7,777	1.04
2.00	Outlier Payments	355,057	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	10,033,329	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	10,033,329	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	10,033,329	9.00
10.00	Deductibles	18,304	10.00
11.00	Subtotal (line 9 minus line 10)	10,015,025	11.00
12.00	Coinsurance	557,403	12.00
13.00	Subtotal (line 11 minus line 12)	9,457,622	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	279,512	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	181,683	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	197,799	16.00
17.00	Subtotal (sum of lines 13 and 15)	9,639,305	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	9,639,305	22.00
22.01	Sequestration adjustment (see instructions)	95,429	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	9,633,125	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	-89,249	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	355,057	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet G | Date/Time Prepared: 2/25/2021 9:51 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	1,105,220	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	4,189,453	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,724	0	0	0	6.00
7.00	Inventory	180,595	0	0	0	7.00
8.00	Prepaid expenses	506,186	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,975,730	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	123,627	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	187,170	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	623,022	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	30,046	0	0	0	23.00
24.00	Accumulated depreciation	-561,236	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)	402,629	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,544,040	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,544,040	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,922,399	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,587,891	0	0	0	37.00
38.00	Salaries, wages, and fees payable	350,901	0	0	0	38.00
39.00	Payroll taxes payable	-759,855	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-2,455,271	0	0	0	43.00
44.00	Other current liabilities	3,226,889	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,950,555	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,469,068	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,469,068	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,419,623	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,502,776				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)	10,502,776	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,922,399	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet G-1 | Date/Time Prepared: 2/25/2021 9:51 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		9,646,446		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,042,070				2.00
3.00	Total (sum of line 1 and line 2)		11,688,516		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)		11,688,516		0		11.00
12.00	ADJ EQUITY	1,185,740		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)		1,185,740		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,502,776		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	ADJ EQUITY		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: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2021 9:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	47,521,235		47,521,235	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)	47,521,235		47,521,235	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	47,521,235		47,521,235	17.00
18.00	Ancillary services	27,076,077	15,992	27,092,069	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN SERVICES	529,666	0	529,666	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	75,126,978	15,992	75,142,970	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,189,285		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)		15,189,285		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-2028 | Period: From 11/01/2019 To 10/31/2020 | Worksheet G-3 | Date/Time Prepared: 2/25/2021 9:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,142,970	1.00
2.00	Less contractual allowances and discounts on patients' accounts	57,989,779	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,153,191	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,189,285	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,963,906	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,642	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	19,522	24.00
24.50	COVID-19 PHE Funding	54,000	24.50
25.00	Total other income (sum of lines 6-24)	78,164	25.00
26.00	Total (line 5 plus line 25)	2,042,070	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)	2,042,070	29.00