Health Financial Systems FAI RBANKS In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0179 Worksheet S Peri od From 07/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 8/2/2021 3:31 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/2/2021 Time: 3:31 pm use only Manually prepared cost report 2 [] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF 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 OF 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 FAIRBANKS (15-0179) for the cost reporting period beginning 07/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regul ati ons. [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. HOLLY MILLARD (Signed) Officer or Administrator of Provider(s) NETWORK SVP OF FINANCE Title

(Dated when report is electronically signed.)

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	(155, 781	0	0	189	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	6.00
200. 00 Total		155, 781	0	0	189	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTITICATION DA		FIOVIC		l: 15-0179	Period: From 07/ To 12/	01/2020 31/2020	Part I Date/T	ieet S-2 ime Pre)21 3:31	epare
	1.00		00		3.00			4.00			
	Hospital and Hospital Health Care Cor										
	Street: 8102 CLEARVISTA	PO Box:	N 7	in Code	. 4405						1.
0	City: INDIANAPOLIS	State: I Component Na		ip Code CCN	2: 4625 CBSA		nty: MARIO er Date		ent Sys	tom (D	2.
		component ne		umber	Numbe		Certifi		, 0, or		
						51		V	XVIII		1
		1.00		2.00	3.00	0 4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component			,							
		FAI RBANKS	1	50179	2690	0 1	01/10/20	012 N	P	0	3.
	Subprovider - IPF										4
	Subprovider - IRF Subprovider - (Other)			-							5
	Swing Beds - SNF										7
	Swing Beds - NF										8
	Hospi tal -Based SNF										9
	Hospital-Based NF										10.
00	Hospital-Based OLTC										11.
	Hospital-Based HHA										12.
	Separately Certified ASC										13.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
	Hospital-Based Health Clinic - FQHC										16
	Hospital-Based (CMHC) I										17
	Renal Dialysis										18
	Other										19
								om:		0:	-
00	Cast Departing Davied (mp (dd (mp m))							00		00	20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)							1/2020 2	12/3	/2020	20.
00	Type of control (see this full to its)							2			21.
						1.00	2	00	3.	00	1
	Inpatient PPS Information						I				
02	Did this hospital receive interim unc cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N" reporting period occurring on or afte Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi	nn 1, "Y" for yes iod occurring pr for no for the er October 1. (se requires final u port settlement? for no, for the er 1. Enter in co e cost reporting	s or "N" for portion of perinstruct (see instruct (see instr portion co olumn 2, "Y period on	or no fi cober 1 the co cions) ced care of the find the or afte	or ost e s) yes er	YN		YN		N	22.
00	rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for r reporting period occurring on or afte Does this hospital contain at least 1 counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med	Is for delineatin olumn 1, "Y" for g period prior to no for the portic er October 1. (se 100 but not more 2.105)? Enter in dicaid days on li	ng statisti yes or "N" o October 1 on of the c ee instruct than 499 k column 3, nes 24 and	cal and for nu . Ente cost :ions) peds (a: "Y" fo	eas o r s r	.4		N			22.
	below? In column 1, enter 1 if date of if date of discharge. Is the method of reporting period different from the m reporting period? In column 2, enter	of identifying th method used in th	ne days in ne prior co "N" for no In-State	this co ost In-St	ost tate	Out-of	Out-of	Medi ca		Other	
			Medi cai d pai d days 1.00	Medi o el i gi unpa day 2. 0	ble aid /s	State Medicaid paid days 3.00	State Medi cai d el i gi bl e unpai d 4.00	HMO da		edi cai d days 6.00	_
00	If this provider is an IPPS hospital,	enter the	283		0	3.00	4.00		, 0		24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in colu out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but	n 1, in-state umn 2, blumn 3, ldays in column	200			0					

	Financial Systems	FAI RBANKS	Dia anti al ana - 00	N 15 0170	Developed	In Lie	u of Fo		
105PT 1.	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	IN: 15-0179	Period: From 07, To 12,	′01/2020 ′31/2020	Part I Date/T	eet S-2 ime Pre 21 <u>3:31</u>	epared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ays 🛛 Me)ther di cai d days	
05.00		1.00	2.00	3.00	4.00	5.00		6.00	
	If this provider is an LRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0 0		0	0		25.00
						<u>'Rural S</u> . 00		f Geogr 00	-
26.00	Enter your standard geographic classification (not wa		at the beg	ginning of t	the	1			26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r	ural. If ap		st	1			27.00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status in	1	C			35.00
						nni ng:	End		
36.00	Enter applicable beginning and ending dates of SCH st	tatus. Subs	cript line	36 for numb		. 00	2.	00	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ds MDH statu	IS	C	D		37.0
	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	or yes or "	N" for no.	(see					37.0
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 0
						<u>//N</u> . 00		/N 00	-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage i)? Enter	(iii)? Ent requiremer in column 2	ter in colum nts in 2 "Y" for ye	ime in es	N		N	39.0
0.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			N		N	40.0
						V	XVIII 0 2.00	_	-
	Prospective Payment System (PPS)-Capital					- N	N	N	45.0
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1	eption for	extraordi na	ary circumst	ances	N	N N	N	45.0
7.00 8.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o Is the facility electing full federal capital payment	•		5		N	N N	N	47. 0 48. 0
6. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (56. C
7.00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	period duri yes or "N th of this (", complet , if appli	ng which re " for no ir cost report e Worksheet cable.	n column 1. ting period? t E-4. lf co	If column ? Enter " olumn 2 is	Y"			57.0
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.						
9.00	Are costs claimed on line 100 of Worksheet A? If yes	<u>s, complete</u>	<u>Wkst. D-2,</u>	Pt. I. NAHE 413.8 Y/N		N Sheet A ne #	Qual i f	hrough ication on Code	
_		·····		1.00	2	. 00	3.	00	
50. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (see umn 1. If CR) NAHE MA	column 1	N					60.0

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	FAI RBA	Provider CC		eriod: rom 07/01/2020	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 8/2/2021 3:31	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	-
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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) 	N			0.00	0.00	61. C
 D2 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) 						61.0
 1.03 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) 						61.0
 Henter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
1.05 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.C
1.06 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. C
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61. '
 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. 1.20 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		61.2
					1.00	
ACA Provisions Affecting the Health Resources and Ser			. ,			
 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	uctions)	N	63. (
			Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see 	<u>re June</u> ty trair n-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provider CO		eriod: rom 07/01/2020 o 12/31/2020		pared:
	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	1
55.00 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			0. 00	0. 00	0. 000000	65.00
4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current beginning on or after July 1, 207		Nonprovider Setting	sEffective fo	or cost reporti	ng periods	
56.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonpr nweighted non-primar I. Enter in column 3	ovider settings. y care resident the ratio of	0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
_			Si te			
77.00 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 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00 0.00	5.00	67.00
				1.00	0 2.00 3.00	
Inpatient Psychiatric Facility PF						70.01
'0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.		PF), or does it conta	ain an IPF subp	provider? N		70.00
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	the facility have an fore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) aate which program ye	04? Enter "Y" for y lity train residents (D)? Enter "Y" for y	es or "N" for r in a new teach es or "N" for r	no. (see ni ng no.	N O	71.00
5.00 Is this facility an Inpatient Ref	abilitation Facility	(IRF), or does it c	ontain an IRF	N		75.00
subprovider? Enter "Y" for yes a 76.00 If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t CFR 412.424 (d)(1)(iii)(D)? Enter indicate which program year begar	the facility have an ng on or before Nove rain residents in a "Y" for yes or "N"	mber 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	N O	76.00

Health Financial Systems	FAI RBAN	IKS		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provider CCN	1	Period: From 07/01/2020 Fo 12/31/2020	Worksheet S- Part I Date/Time Pr	epared:
					1.00	
Long Term Care Hospital PPS						
80.00 Is this a long term care hospital 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 (FR Section §413.40(f)(1)(i)	TEERA? Enter	"Y" for ves	or "N" for no.	N	85.00
86.00 Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for	Other subprovider (excluded					86.00
87.00 Is this hospital an extended neor 1886(d)(1)(B)(vi)? Enter "Y" for	olastic disease care hospital	l classified un	nder section		N	87.00
				V 1.00	XI X 2.00	_
Title V and XIX Services				1		
90.00 Does this facility have title V a yes or "N" for no in the applicab		I services? En	ter "Y" for	N	N	90.00
91.00 Is this hospital reimbursed for t full or in part? Enter "Y" for ye	itle V and/or XIX through th		either in	N	Y	91.00
92.00 Are title XIX NF patients occupy instructions) Enter "Y" for yes o	ng title XVIII SNF beds (dua	al certificatio	on)? (see		N	92.00
93.00 Does this facility operate an ICF "Y" for yes or "N" for no in the	/IID facility for purposes of		XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capita applicable column.		and "N" for no	in the	N	N	94.00
95.00 If line 94 is "Y", enter the redu	ction percentage in the app	licable column.		0.00	0.00	95.00
96.00 Does title V or XIX reduce operat applicable column.	ing cost? Enter "Y" for yes	or "N" for no	in the	N	Ν	96.00
97.00 If line 96 is "Y", enter the redu 98.00 Does title V or XIX follow Medica				0. 00 Y	0.00 Y	97.00
stepdown adjustments on Wkst. B,	Pt. I, col. 25? Enter "Y" fo				I	98.00
column 1 for title V, and in colu 98.01 Does title V or XIX follow Medica C, Pt. I? Enter "Y" for yes or "N	nre (title XVIII) for the rep			Y	Y	98.01
 title XIX. 98.02 Does title V or XIX follow Medica bed costs on Wkst. D-1, Pt. IV, I 				Y	Y	98. 02
for title V, and in column 2 for 98.03 Does title V or XIX follow Medica reimbursed 101% of inpatient serv	nre (title XVIII) for a criti			N	N	98.03
for title V, and in column 2 for 98.04 Does title V or XIX follow Medica outpatient services cost? Enter "	nre (title XVIII) for a CAH n			Ν	N	98.04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medica	-			Y	Y	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" column 2 for title XIX.	for yes or "N" for no in co	olumn 1 for ti	tle V, and ir			
98.06 Does title V or XIX follow Medica Pts. I through IV? Enter "Y" for column 2 for title XIX.				Y	Y	98.06
Rural Providers					l	
105.00 Does this hospital qualify as a (106.00 If this facility qualifies as a (inclusive meth	nd of navment	N N		105.00 106.00
for outpatient services? (see ins	structions)		1 5			
107.00 Column 1: If line 105 is Y, is th training programs? Enter "Y" for Column 2: If column 1 is Y and I	yes or "N" for no in column	1. (see inst	ructions)	N		107.00
approved medical education progra Enter "Y" for yes or "N" for no i			nit(s)?			
108.00 Is this a rural hospital qualifyi CFR Section §412.113(c). Enter "N	ng for an exception to the (ule? See 42	N		108. 00
		Physi cal	Occupational		Respi ratory	,
109.00 If this hospital qualifies as a (CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outs for yes or "N" for no for each th	side supplier? Enter "Y"					
					1.00	-
110.00 Did this hospital participate in					N	110.00
Demonstration)for the current cos complete Worksheet E, Part A, lir applicable.						

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	1	Period: From 07/01/2020 Fo 12/31/2020	u of Form CMS Worksheet S- Part I Date/Time Pr 8/2/2021 3:3	2 epared:
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter inter the column 2.	1.00 N	2.00	111.0
	1.00	2.00	3.00	-
12.00 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. Miscellaneous Cost Reporting Information	N			112. 0
15.00 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			0115.0
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Ν			116.0
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.0
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118. 0
	Premi ums	Losses	I nsurance 3. 00	
18.01 List amounts of malpractice premiums and paid losses:	82, 12	8 0		0118.0
18.02 Are mal practice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.		1.00 N	2.00	118. (
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instruc- tor in column 2, "N" for use or "N" for period.	for yes or e Outpatient	N	Ν	119. (120. (
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices	charged to	N		121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		N		122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N		125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certif	ication date			126.
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certifi	cation date			127.
in column 1 and termination date, if applicable, in column 2. 28.00 f this is a Medicare certified liver transplant center, enter the certifi				128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific				129.0
column 1 and termination date, if applicable, in column 2.				130.
00.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.				131.0
 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2. 				
 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 				
 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the certification of the center of the cen	cation date			132. (133. (134. (

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		FAI RBANKS A	Provider CC	N: 15-0179			u of Form CMS Worksheet S- Part I Date/Time Pr 8/2/2021 3:3	-2 repared:
1.00		2.00				3.00	0/2/2021 0.0	
If this facility is part of a cha					name an	d address	of the	
141.00 Name: COMMUNITY HEALTH NETWORK	<u>fice contractor name</u> Contractor's Na		NSON PHYSICI		tor's Nu	umber: 0810)1	141.00
142.00Street: 1500 N RITTER	PO Box:	SERVI	JES					142.00
143.00 City: INDIANAPOLIS	State:	I N		Zip Cod	e:	4621	9-3095	143.00
							1.00	_
144.00 Are provider based physicians' cos	sts included in Works	heet A?					1.00 Y	144.00
		74				1.00	2.00	145.00
 145.00 If costs for renal services are clipatient services only? Enter "Y' no, does the dialysis facility inceperiod? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or service) 	for yes or "N" for clude Medicare utiliz for no in column 2. gy changed from the p n column 1. (See CMS	no in col ation for previously Pub. 15-2	umn 1. lf c this cost filed cost	column 1 is reporting report?	f	N		145. 00
	u/yyyy) in corunn 2.							
							1.00	
147.00Was there a change in the statisti 148.00Was there a change in the order of 149.00Was there a change to the simplifi	allocation? Enter "	Y" for y€	es or "N" fo	or no.	r no		N N N	147.00 148.00 149.00
	the cost finding moth		Part A	Part B		ītle V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155.00Hospi tal			N	N		N	N	155. 0
156.00 Subprovider - IPF 157.00 Subprovider - IRF			N N	N N		N N	N N	156.0
158. 00 SUBPROVI DER			IN			IN	IN IN	157.00
159. 00 SNF			N	N		Ν	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 165.00Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that h	as one or	more campu	ıses in diff	erent CE	BSAs?	N	165. 0
	Name	(County	State Z	ip Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.00	4.00	5.00	0 1 (/ 0
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)							0.0	00 166. 00
							1.00	
Health Information Technology (HI					ent Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10) ontor	c the	Y	167. 0 168. 0
reasonable cost incurred for the H				, 107 13 1	, enter	110		00.0
68.01 If this provider is a CAH and is r	not a meaningful user	, does th				dshi p		168. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u						ontor the		99169.0
transition factor. (see instruction			not a CAH (ini), €		9.0	77107.0
					Be	egi nni ng	Endi ng	_
70.00 Enter in columns 1 and 2 the EHR L	peginning date and en	nding date	e for the re	eporting		1.00	2.00	170.00
						4 . 0.0		_
171.00 f ine 167 is "Y", does this prov section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3 umn 1. If column 1 is	8, Pt. I,	line 2, col	. 6? Enter	on	<u>1.00</u> N	2.00	0 171. 00

iospi t.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S- Part II Date/Time Pro 8/2/2021 3:3	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	er all dates in t	he	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
I. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				
			Y/N	Date	V/I	_
2.00	Has the provider terminated participation in the Medicare Pr	rogrom2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A	03/25/2021	4.0
5.00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N	Y/N		5.0
				1.00	Legal Oper. 2.00	
	Approved Educational Activities					
	Column 1: Are costs claimed for nursing school? Column 2:	lf yes, is th	ne provider is	s N		6.0
	the legal operator of the program?					
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		during the	N N		7.0
9.00	Are costs claimed for Interns and Residents in an approved g		cal education	Ν		9.0
10.00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
					Y/N 1.00	_
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			ost reporting	Y N	12. 0 13. 0
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	°yes, see ins	structions.	Ν	14. (
5.00	Did total beds available change from the prior cost reportin	<u><u>v</u> i</u>	-		N + P	15.0
		Y/N	rt A Date	Par Y/N	<u>тв</u> Date	
	-	1.00	2.00	3.00	4.00	
	PS&R Data					
6.00	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)	Ν		N		16.0
7.00	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	Y	07/01/2021	Y	07/01/2021	17.0
8. 00	in columns 2 and 4. (see instructions) 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	Ν		Ν		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		repared:
			i pti on	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.00
	Report data for Other? Describe the other adjustments:					
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	_
21.00	Was the cost report prepared only using the provider's	N 1.00	2.00		4.00	21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)			
22.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see					22.00
22.00	Have changes occurred in the Medicare depreciation expense		sals made du	ring the cost		22.00
	reporting period? If yes, see instructions.	ado to apprais		ing the boot		20100
4.00	Were new leases and/or amendments to existing leases entered	ed into during	this cost re	eporting period?		24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	rtina periodí	?lfves.see		25.00
	instructions.		0 1	5		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see		26.00
27.00	Has the provider's capitalization policy changed during the	e cost reportir	ng period? It	°yes, submit		27.00
	copy.	•				_
8 00	Interest Expense Were new Loans, mortgage agreements or letters of credit en	ntered into du	ing the cost	t reporting	1	28.00
	period? If yes, see instructions.		-			20.00
29.00	Did the provider have a funded depreciation account and/or	•	ebt Service F	Reserve Fund)		29.00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled matu		debt? If ves	s. see		30.00
	instructions.	5	5			
31.00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see		31.00
	Purchased Servi ces				1	
32.00	Have changes or new agreements occurred in patient care set		ed through co	ontractual		32.00
33.00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competi	tive biddina? If		33.00
	no, see instructions.		5 1	5		1 33.00
	Provider-Based Physicians	crangement with	n providor b	acod physicians?		
	Provider-Based Physicians Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	n provi der-ba	ased physi ci ans?	Y	
34. 00	Are services furnished at the provider facility under an au If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	isting agreemer	•			34.00
34. 00	Are services furnished at the provider facility under an ailf yes, see instructions.	isting agreemer	•	provi der-based	Y	34.00
34. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in	isting agreemer	•		Y	34.00
34.00 35.00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs	isting agreemer	•	provi der-based Y/N 1.00	Y N Date	34.00
34. 00 35. 00 36. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report?	isting agreemer nstructions.	nts with the	provi der-based <u>Y/N</u> 1.00 N	Y N Date	34. 00
34. 00 35. 00 36. 00 37. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions.	isting agreemen nstructions.	home office	provi der-based Y/N 1.00 N	Y N Date	34. 00 35. 00 36. 00 37. 00
34. 00 35. 00 36. 00 37. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes , was the fiscal year end of the home office for t	isting agreemen nstructions. repared by the fice different	hts with the	provi der-based Y/N 1.00 N	Y N Date	34. 00 35. 00 36. 00 37. 00
34. 00 35. 00 36. 00 37. 00 38. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions.	isting agreemen nstructions. repared by the fice different d of the home of	hts with the home office from that of	provi der-based Y/N 1.00	Y N Date	34. 00 35. 00 36. 00 37. 00 38. 00
 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	isting agreemennstructions.	home office from that of office. hents? If yes	provi der-based Y/N 1.00	Y N Date	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	isting agreemennstructions.	home office from that of office. hents? If yes	provi der-based Y/N 1.00	Y N Date	34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	isting agreemennstructions.	home office from that of office. hents? If yes If yes, see	provi der-based Y/N 1.00 N S,	Y N Date 2.00	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
 34.00 35.00 36.00 37.00 38.00 39.00 	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pilf yes, see instructions. If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions.	isting agreemennstructions.	home office from that of office. hents? If yes	provi der-based Y/N 1.00 N S,	Y N Date	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulties, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions.	isting agreemennstructions.	home office from that of office. hents? If yes If yes, see	Y/N Y/N 1.00 N S, 2 2	Y N Date 2.00	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulling yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions.	isting agreemennstructions.	home office from that of office. hents? If yes If yes, see	provi der-based Y/N 1.00 N S,	Y N Date 2.00	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pullinges, see instructions. If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	repared by the fice different d of the home of er chain compor home office?	home office from that of office. hents? If yes If yes, see	Y/N Y/N 1.00 N S, 2 2	Y N Date 2.00	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 	Are services furnished at the provider facility under an ailf yes, see instructions. If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulling yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions.	isting agreemennstructions.	home office from that of office. hents? If yes If yes, see	Y/N Y/N 1.00 N S, 2 2	Y N Date 2.00	34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00

Heal th	Financial Systems FAIR	BANK	<s< th=""><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></s<>	In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0179	riod: om 07/01/2020 12/31/2020		
		_			8/2/2021 3:31	pm
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	MA	NAGER			41.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost					43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	FAI RBA	NKS		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 07/01/2020 To 12/31/2020	Date/Time Prep 8/2/2021 3:31	pared:
						I/P Days / O/P	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	<u>Visits / Trips</u> 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) HMO and other (see instructions)	30. 00	86	15, 82	0.00	0	1.00
3.00	HMO I PF Subprovi der						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)		86	15, 82	0.00	0	7.00
8.00							8.00 9.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	33.00	0		0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		86	15, 82	. 00	0	14.00
15.00	CAH visits		00	10,02	0.00	0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						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)		86				27.00
28.00 29.00	Observation Bed Days Ambulance Trips					0	28.00 29.00
29.00	Employee discount days (see instruction)						30.00
30.00	Employee discount days (see fistraction)						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0		3		32.00
52.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges					1	33.01

	Financial Systems	FAI RBAN				eu of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC		Period: From 07/01/2020 To 12/31/2020		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	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 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	259 0 0 0 259 0	283 0 0 0 283 0 283	6, 27 6, 27	0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00 \end{array}$	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	259 0	283 0	6, 27	0	101. 85	12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) ITCH page provend days	0 0 0	0 0 0		0 0.00 0.00 0 0 0 0		27.00 28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	COMPLEX STATISTICAL DATA		CN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 8/2/2021 3:31	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 01\\ \end{array}$	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) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00	0		56 63 0 0 56 63	1, 050	$\begin{array}{c} 1. \ 00\\ \\ 2. \ 00\\ \\ 3. \ 00\\ \\ 4. \ 00\\ \\ 5. \ 00\\ \\ 6. \ 00\\ \\ 7. \ 00\\ \\ 8. \ 00\\ \\ 9. \ 00\\ \\ 10. \ 00\\ \\ 11. \ 00\\ \\ 12. \ 00\\ \\ 13. \ 00\\ \\ 13. \ 00\\ \\ 13. \ 00\\ \\ 14. \ 00\\ \\ 15. \ 00\\ \\ 14. \ 00\\ \\ 15. \ 00\\ \\ 20. \ 00\\ \\ 21. \ 00\\ \\ 22. \ 00\\ \\ 23. \ 00\\ \\ 24. \ 10\\ \\ 25. \ 00\\ \\ 26. \ 00$
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

ΡΙΤ	Financial Systems AL WAGE INDEX INFORMATION		FAI RB	Provider C	F	Period: From 07/01/2020 To 12/31/2020		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200. 00	6, 763, 255	-23, 639	6, 739, 616	211, 842. 00	31. 81	1.
0	instructions) Non-physician anesthetist Part		C	0	l c	0.00	0.00	2.
	A					0.00	0.00	2.
0	Non-physician anesthetist Part		C	0	C	0.00	0.00	3.
0	Þ Physician-Part A -		C	0	C	0.00	0.00	4.
1	Administrative						0.00	
1 0	Physicians - Part A - Teaching Physician and Non		0 173, 558	-	173, 558	0.00 1,216.00		
	Physician-Part B							
0	Non-physician-Part B for hospital-based RHC and FQHC		C	0	C	0.00	0.00	6
	servi ces							
0	Interns & residents (in an	21.00	C	0	C	0.00	0.00	7
1	approved program) Contracted interns and		C	0	C	0.00	0.00	7
	residents (in an approved							
0	programs) Home office and/or related		C	0		0.00	0.00	8
	organization personnel							
0 00	SNF Excluded area salaries (see	44.00	C 435, 824	0 0	437, 068			
00	instructions)		435, 624	1, 244	437,000	10, 372.00	23.79	
	OTHER WAGES & RELATED COSTS		4.05		4.05		45.00	
00	Contract Labor: Direct Patient Care		135	0	135	3.00	45.00	11
00	Contract Labor: Top Level		C	0	C	0.00	0.00	12
	management and other management and administrative							
	servi ces							
00	Contract Labor: Physician-Part A - Administrative		C	0	C	0.00	0.00	13
00	Home office and/or related		C	0	C	0.00	0.00	14
	organization salaries and							
01	wage-related costs Home office salaries		929, 988	0	929, 988	19, 475. 00	47. 75	14
	Related organization salaries		C		c c		0.00	14
00	Home office: Physician Part A - Administrative		C	0	C	0.00	0.00	15
00	Home office and Contract		C	0	C	0. 00	0.00	16
01	Physicians Part A - Teaching		<i>.</i>			0.00	0.00	1/
01	Home office Physicians Part A - Teaching		C	0		0.00	0.00	
02	Home office contract		C	0	C	0.00	0.00	16
	Physicians Part A - Teaching WAGE-RELATED COSTS							
	Wage-related costs (core) (see		1, 400, 656	0	1, 400, 656	b		17
00	instructions) Wage-related costs (other)							18
	(see instructions)							
00	Excluded areas		123, 584	0	123, 584	1		19
00	Non-physician anesthetist Part A		Ĺ	, 0				20
00	Non-physician anesthetist Part		C	0	c)		21
00	B Physician Part A -		C	0	()			22
	Admi ni strati ve							
01 00	Physician Part A - Teaching Physician Part B		C 11, 742	0	C 11, 742			22
00	Wage-related costs (RHC/FQHC)		(1, 742 C	0	C			23
00	Interns & residents (in an		C	0	C)		25
50	approved program) Home office wage-related		208, 691	0	208, 691			25
	(core)							
51	Related organization wage-related (core)		C	0	C			25
52	Home office: Physician Part A		C	0	c c			25
	- Administrative -							

Heal th	Financial Systems		FAI RB/	ANKS		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col	. Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00	90, 869		90, 86			
27.00	Administrative & General	5.00	1, 493, 109					
28.00	Administrative & General under		140, 596	0	140, 59	739.00	190. 25	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	147, 924	0	147, 92			
31.00	Laundry & Linen Service	8. 00	0	0		0 0.00		
32.00	Housekeepi ng	9.00	217, 253	0	217, 25			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Di etary	10.00	133, 557	-35, 774	97.78	4, 696. 00	20.82	34.00
35.00	Dietary under contract (see	10.00	149, 975		149, 97			
55.00	instructions)		147, 775	0	147, 77	3 7, 310.00	20.30	33.00
36.00	Cafeteri a	11.00	0	35, 774	35, 77	74 1, 718. OC	20. 82	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0		0 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	0	0		0 0.00	0.00	40.00
41.00	Medical Records & Medical	16.00	122,007	0	122, 00	5, 176. 00		
	Records Library							
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

Heal th	Financial Systems	FAI RBANKS				In Lieu of Form CMS-2552-10			
HOSPI	AL WAGE INDEX INFORMATION			Provider CO		Period: From 07/01/2020	Worksheet S-3 Part III		
						To 12/31/2020	Date/Time Pre		
						1	8/2/2021 3:31		
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4	, , , , , , , , , , , , , , , , , , ,		
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		6, 880, 268	-23, 639	6, 856, 62	9 218, 681. 00	31.35	1.00	
	instructions)								
2.00	Excluded area salaries (see		435, 824	1, 244	437, 06	8 18, 372. 00	23. 79	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		6, 444, 444	-24, 883	6, 419, 56	1 200, 309. 00	32.05	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		930, 123	0	930, 12	3 19, 478. 00	47.75	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		1, 609, 347	0	1, 609, 34	7 0.00	25.07	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		8, 983, 914	-24, 883	8, 959, 03	1 219, 787. 00	40. 76	6.00	
7.00	Total overhead cost (see		2, 495, 290	-7, 143	2, 488, 14	7 71, 712. 00	34.70	7.00	
	instructions)								

Heal th	Financial Systems	FAI RBANKS	S	In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE RELATED COSTS		Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Pre 8/2/2021 3:31	pared:
					Amount	p
					Reported	
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				33, 402	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution				00, 102	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instru		0	3.00		
4.00	Qualified Defined Benefit Plan Cost (see instructi		0	4.00		
	PLAN ADMINISTRATIVE COSTS (Paid to External Organi					
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 Part				0	8. 01
8.02	Health Insurance (Self Funded with a Third Party A	Administrator	-)		482, 290	8. 02
8.03	Health Insurance (Purchased)				0	8.03
9.00	Prescription Drug Plan				82, 487	
10.00	Dental, Hearing and Vision Plan				4, 701	
11.00	Life Insurance (If employee is owner or beneficiar				177, 550	
12.00	Accident Insurance (If employee is owner or benefi				0	12.00
13.00	Disability Insurance (If employee is owner or bene				55, 403	
14.00	Long-Term Care Insurance (If employee is owner or	benefi ci ary)			0	14.00
15.00	'Workers' Compensation Insurance				4, 281	15.00
16.00	Retirement Health Care Cost (Only current year, no	ot the extrac	ordinary accruai require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES					
17.00	FICA-Employers Portion Only				459, 040	17.00
18.00	Medicare Taxes - Employers Portion Only				439,040	18.00
19.00	Unemployment Insurance				0	19.00
20.00	State or Federal Unemployment Taxes				0	20.00
20.00	OTHER					20.00
21.00	Executive Deferred Compensation (Other Than Retire instructions))	ement Cost Re	eported on lines 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement		236, 828	23.00		
24.00	Total Wage Related cost (Sum of lines 1 -23)	1, 535, 982	24.00			
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Heal th	Financial Systems	FAI RBANKS	In Lieu of Form CMS-2552-10			
HOSPI T	TAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0179	Peri od:	Worksheet S-3		
			From 07/01/2020 To 12/31/2020	Part V Date/Time Pre	norod.	
			To 12/31/2020	8/2/2021 3:31		
	Cost Center Description		Contract Labor	Benefit Cost		
	·		1.00	2.00		
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identification	on:				
1.00	Total facility's contract labor and benefit cost		135	1, 535, 982	1.00	
2.00	Hospi tal		135	1, 412, 398	2.00	
3.00	Subprovider - IPF				3.00	
4.00	Subprovider - IRF				4.00	
5.00	Subprovider - (Other)		0	0	5.00	
6.00	Swing Beds - SNF		0	0	6.00	
7.00	Swing Beds - NF		0	0	7.00	
8.00	Hospital-Based SNF				8.00	
9.00	Hospital-Based NF				9.00	
10.00	Hospital-Based OLTC				10.00	
11.00	Hospital-Based HHA				11.00	
12.00	Separately Certified ASC				12.00	
13.00	Hospi tal-Based Hospi ce				13.00	
14.00	Hospital-Based Health Clinic RHC				14.00	
15.00	Hospital-Based Health Clinic FQHC				15.00	
16.00	Hospi tal -Based-CMHC				16.00	
17.00	Renal Dialysis				17.00	
18.00	Other		0	123, 584	18.00	

Heal th	Financial Systems	FAI RBANKS		In Lie	eu of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0179	Period:	Worksheet S-1		
				From 07/01/2020			
				To 12/31/2020			
					8/2/2021 3: 31	piii	
					1.00		
	Uncompensated and indigent care cost computation				1 1100		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 of	column 3 divided by li	ne 202 column	8)	0, 577970	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				183, 228	2.00	
3.00	Did you receive DSH or supplemental payments from Me	edi cai d?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or		s from Medica	i d?	Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental	payments from Medicai	d		0	5.00	
6.00	Medi cai d charges		1, 367, 653	6.00			
7.00	Medicaid cost (line 1 times line 6)		790, 462	7.00			
8.00	Difference between net revenue and costs for Medicai	id program (line 7 min	nus sum of lin	es 2 and 5; if	607, 234	8.00	
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see inst	tructions for each lin	ie)				
9.00	Net revenue from stand-al one CHIP				0		
10.00	Stand-alone CHIP charges	0					
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10)	along CHID (Ling 11 mi	nuc lino 0, i	f , zoro thon	0		
12.00	Difference between net revenue and costs for stand-a enter zero)	arone chip (inne in mi	nus i i ne 9; i	i < zero then	0	12.00	
	Other state or local government indigent care progra	am (see instructions f	or each line)				
13.00	Net revenue from state or local indigent care progra)	0	13.00	
14.00	Charges for patients covered under state or local in				0		
	10)						
15.00	State or local indigent care program cost (line 1 ti	mes line 14)			0	15.00	
16.00	Difference between net revenue and costs for state of	or local indigent care	e program (lin	e 15 minus line	0	16.00	
	13; if < zero then enter zero)	-					
	Grants, donations and total unreimbursed cost for Me	edicaid, CHIP and stat	e/local indig	ent care progra	ms (see		
	instructions for each line)					1	
17.00	Private grants, donations, or endowment income restr				0		
18.00 19.00	Government grants, appropriations or transfers for s Total unreimbursed cost for Medicaid, CHIP and stat			(our of lines	0 607, 234		
19.00	8, 12 and 16)	te and rocar rhurgent	care programs	(Sum of Times	007,234	19.00	
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col. 2)		
	1		1.00	2.00	3.00		
	Uncompensated Care (see instructions for each line)		1		1		
20.00	Charity care charges and uninsured discounts for the	e entire facility	176, 09	9 152, 127	328, 226	20.00	
04 00	(see instructions)		101 70	450.407	050.007	01 00	
21.00	Cost of patients approved for charity care and uning instructions)	sured discounts (see	101, 78	152, 127	253, 907	21.00	
22.00	Payments received from patients for amounts previous	sly written off as		0 0	0	22.00	
22.00	charity care	siy witten off as		0		22.00	
23.00	Cost of charity care (line 21 minus line 22)		101, 78	0 152, 127	253, 907	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges	s for patient days bey	ond a length	of stay limit	N	24.00	
	imposed on patients covered by Medicaid or other inc	digent care program?					
25.00	If line 24 is yes, enter the charges for patient day	ys beyond the indigent	care program	's length of	0	25.00	
	stay limit						
26.00	Total bad debt expense for the entire hospital compl		828, 036				
27.00	Medicare reimbursable bad debts for the entire hospi				0		
27.01	Medicare allowable bad debts for the entire hospital		0				
28.00	Non-Medicare bad debt expense (see instructions)				828, 036	•	
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare k		instructions)		478, 580 732, 487		
	Cost of uncompensated care (line 23 column 3 plus li Total unreimbursed and uncompensated care cost (line				1, 339, 721		
31.00	Total unreinibulseu anu uncompensateu care cost (TINE	e ia prus rine 30)			1, 339, 721	1 31.00	

Health Financial Systems	KS	S In Lieu of			2552-10	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Period:	Worksheet A	
				From 07/01/2020 To 12/31/2020	Date/Time Pre	pared [.]
					8/2/2021 3:31	
Cost Center Description	Sal ari es	Other		Recl assi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00 00100 CAP REL COSTS-BLDG & FLXT		0		0 512, 448	512, 448	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	90, 869	2, 253	93, 12			
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 493, 109	3, 259, 056			4, 445, 248	5.00
7.00 00700 OPERATION OF PLANT	147, 924	368, 458	516, 38			7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.00
9.00 00900 HOUSEKEEPI NG	217, 253	101, 244	318, 49	7 -3, 176	315, 321	9.00
10. 00 01000 DI ETARY	133, 557	356, 616	490, 17	3 -135, 831	354, 342	10.00
11. 00 01100 CAFETERI A	0	0		0 129, 636	129, 636	11.00
16.00 01600 MEDICAL RECORDS & LIBRARY	122, 007	41, 009	163, 01	6 0	163, 016	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				Т		
30. 00 03000 ADULTS & PEDI ATRI CS	3, 309, 229	1, 692, 443				
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
ANCI LLARY SERVI CE COST CENTERS	-					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 905				
60. 00 06000 LABORATORY	0	75, 956			75, 956	•
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	158, 854	158, 85	4 -2, 293	156, 561	73.00
OUTPATIENT SERVICE COST CENTERS	594, 295	802, 963	1, 397, 25	8 - 129, 633	1, 267, 625	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	594, 295 219, 188	212, 371	431, 55			•
SPECIAL PURPOSE COST CENTERS	219,100	212, 371	431, 33	7 0	431, 339	73.77
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 327, 431	7, 073, 128	13, 400, 55	9 43, 268	13, 443, 827	118 00
NONREI MBURSABLE COST CENTERS	0,027,101	7,070,120	10, 100, 00	10,200	10, 110, 027	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28, 361	28, 36	1 0	28, 361	190.00
194. 00 07950 EAP	0	0		0 0		194.00
194. 01 07951 FAI RBANKS I NSTI TUTE	411, 946	570, 473	982, 41	9 -30, 687	951, 732	194.01
194.0207952 OTHER NON-REIM	0	0		0 0	0	194. 02
194. 03 07953 MARKETI NG	26, 300	120, 625	146, 92	5 -12, 581		
194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY)	-2, 422	-777	-3, 19	9 0	-3, 199	194.04
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 763, 255	7, 791, 810	14, 555, 06	5 0	14, 555, 065	200. 00

Heal th	Financial Systems	FAI RBA	ANKS		In Lieu of Form CMS-2552-10		
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 1	15-0179	Peri od:	Worksheet A	
					From 07/01/2020		
					To 12/31/2020	Date/Time Pr 8/2/2021 3:3	
	Cost Center Description	Adjustments	Net Expenses				
			For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						_
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	512, 448				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	375, 949					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-2, 265, 419					5.00
7.00	00700 OPERATION OF PLANT	0	499, 092				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900 HOUSEKEEPI NG	0	315, 321				9.00
10.00	01000 DI ETARY	0	354, 342				10.00
11.00	01100 CAFETERI A	-31, 601	98, 035				11.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2, 933	160, 083				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-1, 027, 059	3, 970, 937				30.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0				33.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 905				54.00
60.00	06000 LABORATORY	-387, 232	-311, 276				60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	156, 561				73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	-745, 688	521, 937				90.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	-155, 887	275, 672				93.99
	SPECIAL PURPOSE COST CENTERS		i				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-4, 239, 870	9, 203, 957				118.00
	NONREI MBURSABLE COST CENTERS		i				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28, 361				190.00
194.00	07950 EAP	0	0				194.00
194.01	07951 FAI RBANKS I NSTI TUTE	0	951, 732				194.01
194.02	07952 OTHER NON-REIM	0	0				194.02
194.03	07953 MARKETI NG	0	134, 344				194.03
	07954 RECOVERY SCHOOL/(HOPE ACADEMY)	3, 199					194.04
200.00		-4, 236, 671					200.00

Health Financial Systems RECLASSIFICATIONS

FAI	RBANKS	S
		Pr

In Lieu of Form CMS-2552-10 Worksheet A-6

rovi der	CCN:	15-0179			l
			From	07/01/2020	

					To 12/	31/2020		epared:
							8/2/2021 3:3	1 pm
	Cost Center	Increases Line #	Calami	Other				
	2.00	3.00	Salary 4.00	5.00				
	A - Cafeteria	3.00	4.00	5.00				
1.00	CAFETERIA	11.00	35, 774	93, 862				1.00
1.00	TOTALS		35, 774	93, 862				1.00
	B - Depreciation	I I	33, 774	75,002				-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	352, 529				1.00
2.00		0.00	0	002,027				2.00
3.00		0.00	o	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	o	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
	TOTALS			352, 529				
	C - Other Capital Rental							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159, 919				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00	<u> </u>	0.00	0	0				7.00
	TOTALS		0	159, 919				
	D - STD BENEFIT							_
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	7, 143				1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10, 887				2.00
3.00	CLINIC	90.00	0	6, 853				3.00
4.00	FAI RBANKS INSTITUTE	1 <u>94.</u> 01	0	<u> </u>				4.00
	TOTALS		0	26, 061				_
1 00	E - MOVE NEG SAL TO OTH TO EL		0.400					1 00
1.00	RECOVERY SCHOOL/(HOPE	194.04	2, 422	0				1.00
	ACADEMY)	\vdash — — $+$		— — _–				
500 00	Grand Total: Increases		38, 196	632, 371				500, 00
500.00	loranu rotar. Thereases		30, 190	032, 371				1 500.00

Heal th	Fi nanci al	Systems					
RECLASSI FI CATI ONS							

In Lieu of Form CMS-2552-10

Provider CCN: 15-0179 Period:

 Period:
 Worksheet A-6

 From 07/01/2020
 Date/Time Prepared:

 To
 12/31/2020
 Date/Time Prepared:

						10 12/01/2020	8/2/2021 3: 31 pm
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00		
	A - Cafeteria						
1.00	DI ETARY	10.00	35, 774	93, 862		0	1.00
	TOTALS		35, 774	93, 862	!	7	
	B - Depreciation	· · ·	· · · · · ·				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	271, 101		9	1.00
2.00	OPERATION OF PLANT	7.00	0	16, 788		o	2.00
3.00	HOUSEKEEPI NG	9.00	0	1, 600)	o	3.00
4.00	DI ETARY	10.00	o	6, 027		o	4.00
5.00	ADULTS & PEDIATRICS	30.00	o	3, 415	i i	o	5.00
6.00	CLINIC	90.00	0	10, 330		o	6.00
7.00	FAI RBANKS I NSTI TUTE	194.01	o	30, 687		ol	7.00
8.00	MARKETING	194.03	0	12, 581		0	8,00
	TOTALS		— — — d	352, 529		1	
	C - Other Capital Rental	L L				1	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	35, 816	1	0	1.00
2.00	OPERATION OF PLANT	7.00	0	502		o	2.00
3.00	HOUSEKEEPI NG	9.00	0	1, 576		o	3.00
4.00	DI ETARY	10,00	0	168		0	4,00
5.00	ADULTS & PEDIATRICS	30, 00	o	261		ol	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 293		0	6,00
7.00	CLINIC	90.00	0	119, 303		0	7.00
	TOTALS		— — — d	159, 919		-	
	D - STD BENEFIT	Г				1	
1.00	ADMI NI STRATI VE & GENERAL	5.00	7, 143	0		0	1.00
2.00	ADULTS & PEDIATRICS	30.00	10, 887	0		o	2.00
3.00	CLINIC	90.00	6, 853	0		o	3.00
4.00	FAI RBANKS I NSTI TUTE	194.01	1, 178	0		o	4.00
	TOTALS		26,061	0		1	
	E - MOVE NEG SAL TO OTH TO EL	IM HFS EDIT				- 1	
1.00	RECOVERY SCHOOL/(HOPE	194.04	0	2, 422		0	1.00
	ACADEMY)						
	TOTALS		0	2, 422	!	7	
500.00	Grand Total: Decreases		61, 835	608, 732			500.00
	•						

	Financial Systems	FAI RBA					u of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0179		iod: m 07/01/2020 12/31/2020		pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	230, 000	0		0	0	80, 000	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	15, 768, 941	308, 636		0	308, 636	651, 499	3.00
4.00	Building Improvements	0	0		0	0	-382, 577	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	913, 585	0		0	0	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16, 912, 526	308, 636		0	308, 636	348, 922	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	16, 912, 526	308, 636		0	308, 636	348, 922	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	150, 000	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	15, 426, 078	0					3.00
4.00	Building Improvements	382, 577	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	913, 585	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	16, 872, 240	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	16, 872, 240	0					10.00

Heal th	Financial Systems	FAI RB/	ANKS		In Lie	u of Form CMS-	2552-10
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		pared:
			SL	JMMARY OF CAF	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (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	0		0 0	0	1.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	FAI RBA	ANKS		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2020	Worksheet A-7 Part III	
				To 12/31/2020		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets for Ratio		Insurance	
		Leases	(col. 1 - col	instructions)		
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				-		
1.00 CAP REL COSTS-BLDG & FIXT	15, 958, 654		15, 958, 65			1.00
3.00 Total (sum of lines 1-2)	15, 958, 654		15, 958, 65			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAP					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00 CAP REL COSTS-BLDG & FIXT	0	0		352, 529		1.00
3.00 Total (sum of lines 1-2)	0	•		352, 529	159, 919	3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-		1			
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 0	512, 448	1.00
3.00 Total (sum of lines 1-2)	0	0		0 0	512, 448	3.00

	inancial Systems ENTS TO EXPENSES		FAI RB	Provider CCN: 15-0179 F	Period:	u of Form CMS-2 Worksheet A-8	
					rom 07/01/2020 o 12/31/2020	Date/Time Prep 8/2/2021 3:31	
				Expense Classification on To/From Which the Amount is		07272021 3. 31	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.00	0	1.0
2.00 1	nvestment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.0
. 00 I	OSTS-MVBLE EQUIP (chapter 2) nvestment income - other		0		0.00	0	3.0
	chapter 2) rade, quantity, and time		0		0.00	0	4.0
	liscounts (chapter 8) refunds and rebates of		0		0.00	0	5. C
е	expenses (chapter 8) Nental of provider space by		0		0.00	0	
s	uppliers (chapter 8)		0			-	
s	elephone services (pay tations excluded) (chapter 1)		0		0.00	0	7.0
. 00 T	elevision and radio service chapter 21)		0		0.00	0	8.0
.00 P	arking lot (chapter 21)		0		0.00	0	
а	rovider-based physician djustment	A-8-2	-398, 421			0	
	ale of scrap, waste, etc. chapter 23)		0		0.00	0	11. C
	elated organization ransactions (chapter 10)	A-8-1	-525, 394			0	12. C
3.00 L	aundry and linen service		0		0. 00 0. 00	0	
5.00 R	afeteria-employees and guests vental of quarters to employee		0		0.00	0	
	nd others ale of medical and surgical		0		0.00	0	16. C
	upplies to other than attients						
7.00 S	ale of drugs to other than atients		0		0.00	0	17. C
8.00 S	ale of medical records and		0		0.00	0	18. C
9.00 N e	bstracts lursing and allied health ducation (tuition, fees, ooks, etc.)		0		0.00	0	19. C
0. 00 V	ending machines		0		0.00	0	
i	ncome from imposition of nterest, finance or penalty		0		0.00	0	21.0
2.00 I	harges (chapter 21) nterest expense on Medicare verpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.0
3.00 A t	djustment for respiratory herapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.0
4.00 A	imitation (chapter 14) djustment for physical herapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	66.00		24.0
5.00 U p	imitation (chapter 14) tilization review – hysicians' compensation		0	*** Cost Center Deleted ***	114.00		25. (
6.00 D	chapter 21) epreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.0
7.00 D	OSTS-BLDG & FIXT epreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27.0
	OSTS-MVBLE EQUIP Ion-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.0
D. 00 A	hysicians' assistant djustment for occupational herapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted ***	0.00 67.00	0	29. (30. (
D. 99 H	imitation (chapter 14) lospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 9
1.00 A	nstructions) djustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31. 0
i	athology costs in excess of imitation (chapter 14) AH HIT Adjustment for		0		0.00	0	32. C
	epreciation and Interest		Ū				

Heal th	Financial Systems		FAI RBA	ANKS	In Lie	u of Form CMS-2	2552-10
ADJUS	MENTS TO EXPENSES			Provider CCN: 15-0179	Period:	Worksheet A-8	
					From 07/01/2020 To 12/31/2020		narod
					10 12/31/2020	8/2/2021 3: 31	
				Expense Classification of	on Worksheet A		
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4, 00	5.00	
33.00	REMOVE NEGATIVE NRCC EXPENSE	A		RECOVERY SCHOOL/(HOPE	194.04		33.00
00.00				ACADEMY)			
33. 01	Cafeteria & Coffee Svcs	В	-31,601	CAFETERÍA	11.00	0	33.01
	Revenue						
33. 02	Misc Revenue	В	3, 030	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03	Misc Revenue	В	-2, 933	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	Misc Revenue	В		ADULTS & PEDIATRICS	30.00		33.04
33.05	Misc Revenue	В	-50, 807		90.00		33.05
33.06	Assisted Living Offset	А	-401, 214		90.00		33.06
33.07	Interest Income	В		ADMI NI STRATI VE & GENERAL	5.00		33.07
33.08	Bad Debt	A		ADMI NI STRATI VE & GENERAL	5.00		33.08
33.09	Bad Debt	А		ADULTS & PEDIATRICS	30.00		33.09
33.10	Bad Debt	А	-269, 336		90.00		33.10
33. 11	Bad Debt	A		PARTIAL HOSPITALIZATION PROGRAM	93.99	0	33. 11
33. 12	Sponsorshi p	А	-386	CLINIC	90.00	0	33.12
33. 13	APP	А	-53, 326	ADULTS & PEDIATRICS	30.00	0	33.13
33.14	APP	А	-15, 191	CLINIC	90.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49)		-4, 236, 671				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(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.

Heal th	Financial Systems	FAI RI	BANKS	eu of Form CMS-	2552-10	
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0179	Period:	Worksheet A-8	8-1
OFFICE	COSTS			From 07/01/2020 To 12/31/2020		
	Line No.	Cost Center	enter Expense Items		Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	375, 949	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	170, 377	1, 076, 454	2.00
3.00	30.00	ADULTS & PEDIATRICS	HOME OFFICE	4, 734	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			551, 060	1, 076, 454	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* 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.

nas not	Deen posted to worksheet A,	corumns ranu/or z, the amount	it allowable si	iouru be rhurcateu rh corumn 4	or this part.			
				Related Organization(s) and/or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	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	С	CHNW	100.00	0.00	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				100.00
	non-financial) specify:				1

(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.

Health Financial Systems FAIRBAN	FAI RBANKS			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0179	Period: From 07/01/2020	Worksheet A-8-1	
OFFICE COSTS			Date/Time Prepared:	

			8/2/2021 3: 3	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	375, 949	0		1.00
2.00	-906, 077	0		2.00
3.00	4, 734	0		3.00
4.00	0	0		4.00
5.00	-525, 394			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

nas not	been posted to worksheet A,	corumns randzor z, the amount arrowable should be ridicated in corumn 4 or this part.					
	Related Organization(s)						
	and/or Home Office						
	Type of Business	1					
	6.00	1					
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

i ci indui	
6.00 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
8.00 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.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

	Financial Syste		FAIR	BANKS		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period: From 07/01/2020 To 12/31/2020		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	piii
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		AGGREGATE – ADMI NI STRATI VE & GENERAL	2, 435	2, 435	(0 0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	387, 232	387, 232	(o o	0	2.00
3.00	90.00	AGGREGATE-CLI NI C	8, 754	8, 754	(o o	0	3.00
4.00	0.00		0	0	(o o	0	4.00
5.00	0.00		0	0	(o o	0	5.00
6.00	0.00		0	0	(ol o	0	6.00
7.00	0.00			0	(0	0	7.00
8.00	0.00		0	0	(0	8,00
9.00	0.00			0	(-	0	9,00
10.00	0.00			0	(0	10.00
200.00	0.00		398, 421	398, 421	(0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	200.00
	intot. A Erno #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		i denti i i ei		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	i nour ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMI NI STRATI VE & GENERAL	C		(1.00
2.00		AGGREGATE-LABORATORY	0	0	(o o	0	2.00
2.00		AGGREGATE-CLI NI C		-	(0	3.00
3.00 4.00	90.00 0.00			0	(-	0	3.00 4.00
	0.00			0	(-	4.00 5.00
5.00	0.00			0	(0	
6.00				0		-	-	6.00
7.00	0.00			0	(-	0	7.00
8.00	0.00			0	(-	-	8.00
9.00	0.00		0	Ŭ	(-	0	9.00
10. 00 200. 00	0.00			0	(0	10.00 200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00	-	
1.00		AGGREGATE - ADMI NI STRATI VE &	15.00		17.00			1.00
1.00	5.00	GENERAL				2,430		1.00
2.00		AGGREGATE-LABORATORY	0	0	(2.00
3.00	90.00	AGGREGATE-CLI NI C	0	0	(8, 754		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	(o o		7.00
8.00	0.00		0	0	(o o		8.00
9.00	0.00		0	0	(0 0		9.00
10.00	0.00		0	0	(10.00
200.00			0	0	(398, 421		200.00
		1		•	1			

4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 469,071 9,408 478,479 4.00 5.00 00500 ADMI IN STRATI VE & GENERAL 2,179,829 68,351 106,938 2,355,118 2,355,118 5.05 8.00 00800 LAUNDRY & LI NEN SERVICE 0	Heal th	Financial Systems	FAI RBA	ANKS		In Lie	eu of Form CMS-	2552-10
Cost Center Description Net Expenses for Cost Al location (from West A col. 7) RELATED COSTS BLDG & FLXT Al location (from West A col. 7) EMPLOYEE BENEFITS DEPARTMENT Subtotal ADM INISTRATIVE & GENERAL 0 0.00100 00100 (CAP REL COSTS -BLDG & FLXT 0000 (CAP REL COSTS -BLDG & FLXT 00000 (CAP REL COSTS -BLDG & FLXT 00000 (CAP REL COSTS -BLDG & FLXT 00000 (CAP REL COSTS -BLDG & FLXT 0000 (CAP REL COSTS - BLDG & FLXT 0000 (CAP REL COST CENTERS 00.00 (CAP REL COST CENTERS 0	COST A	LLOCATION - GENERAL SERVICE COSTS				From 07/01/2020	Part I Date/Time Pre	
CENERAL SERVICE COST CENTERS Image: Cost of the co		Cost Center Description	for Cost Allocation (from Wkst A	RELATED COSTS	BENEFITS	Subtotal		
1.00 00100 CAP REL COSTS-BLDG & FIXT 512, 448 512, 448 1, 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 469, 071 9, 408 478, 479 4.00 5.00 00500 ADMIN ISTRATIVE & GENERAL 2, 179, 829 66, 351 106, 938 2, 355, 118 2, 355, 118 5.00 7.00 00700 [DERATION OF PLANT 499, 092 16, 817 10, 645 526, 554 149, 869 7.00 8.00 00800 [AUMONY & LINEN SERVICE 0 0 0 0 8.00 9.00 00900 HOUSEKEEPING 354, 342 70, 912 7, 037 432, 291 123, 040 10.00 11.00 01100 [CAFETERI A 98, 035 0 2, 574 100, 609 28, 636 11.00 11.00 01100 [CAFETERI A 98, 035 0 2, 574 100, 609 28, 636 11.00 12.00 01100 [CAFETERI A 90.00 0 0 0 0 0 0 30.00 30.00 033000 03000 [ADULTS EXPLOTINE SERVICE COST CENTERS <td></td> <td></td> <td>0</td> <td>1.00</td> <td>4.00</td> <td>4A</td> <td>5.00</td> <td></td>			0	1.00	4.00	4A	5.00	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 469, 071 9, 408 478, 479 4, 00 5. 00 00500 ADMI NI STRATI VE & GENERAL 2, 179, 829 68, 351 106, 938 2, 355, 118 5, 00 7. 00 00700 OPERATI ON OF PLANT 499, 092 16, 817 10, 645 526, 554 149, 869 7, 00 8. 00 00800 LAUNDRY & LINEN SERVICE 0							-	
5.00 00500 ADMI NI STRATI VE & GENERAL 2, 179, 829 68, 351 106, 938 2, 355, 118 2, 355, 118 7, 00 7.00 00700 OPERATI ON OF PLANT 499, 092 16, 817 10, 645 526, 554 149, 869 7, 00 8.00 00800 LAUNRY & LINEN SERVICE 0 0 0 0 8.00 9.00 09000 HUJSEKEEPI NG 3315, 321 3, 481 15, 635 334, 437 95, 188 9.00 10.00 DI ETARY 354, 342 70, 912 7, 037 432, 291 123, 040 10.00 11.00 DI 600 MEDI CAL RECORDS & LI BRARY 160, 083 2, 260 8, 780 171, 123 48, 705 16.00 0 0 0 0 0 0 0 0 30.00 03000 ADUNI NE SERVI CE COST CENTERS 3, 970, 937 215, 797 237, 367 4, 424, 101 1, 259, 195 30.00 33.00 03300 BURN INTENSIVE CARE UNIT -311, 276 0 0	1.00	00100 CAP REL COSTS-BLDG & FIXT	512, 448	512, 448				1.00
7.00 00700 0PERATION OF PLANT 499,092 16,817 10,645 526,554 149,869 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0								4.00
8.00 00800 LAUNDRY & LINEN SERVICE 0 <th< td=""><td>5.00</td><td></td><td>2, 179, 829</td><td></td><td>106, 93</td><td>8 2, 355, 118</td><td>2, 355, 118</td><td>5.00</td></th<>	5.00		2, 179, 829		106, 93	8 2, 355, 118	2, 355, 118	5.00
9.00 00900 H0USEKEEPING 315, 321 3, 481 15, 635 334, 437 95, 188 9.00 10.00 01000 DIETARY 354, 342 70, 912 7, 037 432, 291 123, 040 10.00 11.00 01100 CAFETERIA 98, 035 0 2, 574 100, 609 28, 636 11.00 11.00 01600 MEDI CAL_RECORDS & LI BRARY 160, 083 2, 260 8, 780 171, 123 48, 705 16.00 11.00 01000 ARCILLARY SERVICE COST CENTERS	7.00	00700 OPERATION OF PLANT	499, 092	16, 817	10, 64	5 526, 554	149, 869	7.00
10.00 01000 DI ETARY 354,342 70,912 7,037 432,291 123,040 10.00 11.00 01100 CAFETERIA 98,035 0 2,574 100,609 28,636 11.00 16.00 MEDICAL RECORDS & LIBRARY 160,083 2,200 8,780 171,123 48,705 16.00 1NPATI ENT ROUTI NE SERVICE COST CENTERS 3,970,937 215,797 237,367 4,424,101 1,259,195 30.00 30.00 03000 ADULTS & PEDI ATRICS 3,970,937 215,797 237,367 4,424,101 1,259,195 30.00 31.00 03300 BURN INTENSIVE CASE UNIT 0 0 0 0 0 30.00 32.00 D3300 BURN INTENSIVE CAST CENTERS 1,905 0 0,1,905 54.00 0 60.00 LABRARTORY 73.00 0,300 0,300 0 11,276 0 0 0 0.00 0 0.00 171,579 90.00 93.99 09399 PARTI LN ESEVICE COST CENTERS 156,561 0 0 156,561 44,561 73.00 0	8.00		0	0		0 0	0	8.00
11.00 01100 CAFETERIA 99,035 0 2,574 100,609 28,636 11.00 16.00 01600 MEDICAL RECORDS & LIBRARY 160,083 2,260 8,780 171,123 48,705 16.00 10.00 03000 MOULTS & PEDIATRICS 3,970,937 215,797 237,367 4,424,101 1,259,195 30.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 4ANCILLARY SERVICE COST CENTERS	9.00	00900 HOUSEKEEPI NG	315, 321	3, 481	15, 63	334, 437	95, 188	9.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 160,083 2,260 8,780 171,123 48,705 16.00 10.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00					7, 03			10.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1								
30. 00 03000 ADULTS & PEDIATRICS 3, 970, 937 215, 797 237, 367 4, 424, 101 1, 259, 195 30. 00 33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33. 00 ANCILLARY SERVICE COST CENTERS - - 0 0 0 0 0 0 0 0 0 33. 00 60. 00 05400 RADIOLOGY-DIAGNOSTIC 1, 905 0 0 1, 905 54. 00 0 -311, 276 0 60. 00 -311, 276 0 60. 00 -311, 276 0 0 -311, 276 0 0 -311, 276 0 0 0. 00 0 00. 00 0 00. 00 0 00. 00 0 <td< td=""><td>16.00</td><td></td><td>160, 083</td><td>2, 260</td><td>8, 78</td><td>30 171, 123</td><td>48, 705</td><td>16.00</td></td<>	16.00		160, 083	2, 260	8, 78	30 171, 123	48, 705	16.00
33.00 O3300 BURN INTENSIVE CARE UNIT 0							1	
ANCILLARY SERVICE COST CENTERS 54.00 05400 RADIOLOGY-DIAGNOSTIC 1,905 0 0 1,905 54.00 60.00 06000 LABORATORY -311,276 0 0 -311,276 0 60.00 73.00 07300 DRUGS CHARGED TO PATIENTS 156,561 0 0 156,561 44,561 90.00 09000 CLINIC 00175,672 13,168 15,774 304,614 86,700 93.99 98.99 PARTIAL HOSPITALIZATION PROGRAM 275,672 13,168 15,774 304,614 86,700 93.99 99.00 GIPTORE COST CENTERS 5 118.00 0 28,361 0 0 28,361 86,700 93.99 93.99 93.99 93.91 118.00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28,361 0 0 28,361 80.07 194.00 194.00 07950 EAP 0 0 0 0 0 0 194.00				215, 797	237, 36			
54.00 05400 RADI OLOGY-DI AGNOSTI C 1,905 0 1,905 542 54.00 60.00 06000 LABORATORY -311,276 0 0 -311,276 0 60.00 73.00 ORUGS CHARGED TO PATIENTS 156,561 0 0 156,561 44,561 73.00 0UTPATI ENT SERVICE COST CENTERS 0 0 156,561 44,561 73.00 90.00 09000 CLINIC 521,937 38,689 42,275 602,901 171,599 90.00 93.99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 275,672 13,168 15,774 304,614 86,700 93.95 SPECI AL PURPOSE COST CENTERS 5 5 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9,203,957 438,883 447,025 9,098,938 2,008,035 118.00 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28,361 0 0 0 0 0 194.00 0 0 0 0 194.02 0 0 0 0 194.02 0 0 0 0 0 </td <td>33.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>33.00</td>	33.00		0	0		0 0	0	33.00
60.00 06000 LABORATORY -311, 276 0 0 -311, 276 0 60.00 73.00 07300 DRUGS CHARGED TO PATIENTS 156, 561 0 0 156, 561 44, 561 73.00 00 09000 CLI NI C 0 0 156, 561 44, 561 73.00 90.00 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 275, 672 13, 168 15, 774 304, 614 86, 700 93.99 SPECIAL PURPOSE COST CENTERS 5 5 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 203, 957 438, 883 447, 025 9, 098, 938 2, 008, 035 118.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 28, 361 0 0 0 0 194.00 194.00 07950 EAP 0 0 0 0 0 194.00 194.02 07952 OTHER NON-REI M 0 0 0 0 0 194.00 194.02 07952 OTHER NON-REI M 0 0 0 0 194.02 194.02			1					
73.00 07300 DRUGS CHARGED TO PATIENTS 156,561 0 0 156,561 44,561 73.00 00UTPATIENT SERVICE COST CENTERS 90.00 99000 CLINIC 521,937 38,689 42,275 602,901 171,599 90.00 93.99 93.99 99 PARTIAL HOSPITALIZATION PROGRAM 275,672 13,168 15,774 304,614 86,700 93.95 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9,203,957 438,883 447,025 9,098,938 2,008,035 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 28,361 0 0 28,361 8,072 190.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 28,361 0 0 0 0 0 190.00 194.00 0 0 0 0 0 0 0 194.02 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 93.99 09399 PARTI AL HOSPI TALIZATI ON PROGRAM 275, 672 13, 168 15, 774 304, 614 86, 700 93.95 SPECIAL PURPOSE COST CENTERS 521, 937 38, 689 42, 275 602, 901 171, 599 90.00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 203, 957 438, 883 447, 025 9, 098, 938 2, 008, 035 118.00 NONREI MBURSABLE COST CENTERS 500 0 0 0 28, 361 0 0 28, 361 8, 072 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28, 361 0 0 0 0 194.00 194.00 07950 EAP 0 0 0 0 0 0 0 0 194.00 0 0 0 0 0 0 194.00 0 0 0 0 0 0 0 0 0 0 0 0 0								
90.00 09000 CLINIC 521,937 38,689 42,275 602,901 171,599 90.00 93.99 9399 PARTIAL HOSPITALIZATION PROGRAM 275,672 13,168 15,774 304,614 86,700 93.95 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9,203,957 438,883 447,025 9,098,938 2,008,035 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28,361 0 0 0 194.00 0 194.00 0 0 194.00 0 0 0 194.00 0 0 0 194.00 0 0 0 0 194.00 0 0 0 0 194.00 0 0 0 0 194.00 0	73.00		156, 561	0		0 156, 561	44, 561	73.00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM 275,672 13,168 15,774 304,614 86,700 93.95 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9,203,957 438,883 447,025 9,098,938 2,008,035 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28,361 0 0 0 194.00 0 0 0 194.00 0 194.00 0 0 0 0 194.00 0 194.01 07950 EAP 0 0 0 0 194.00 0 194.00 0 0 0 0 194.00 0							I	
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 9, 203, 957 438, 883 447, 025 9, 098, 938 2, 008, 035 118. 00 NONREL MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28, 361 0 0 28, 361 8, 072 190. 00 194.00 07950 EAP 0 0 0 0 194. 00 07950 FAI RBANKS I NSTI TUTE 951, 732 61, 530 29, 561 1, 042, 823 296, 810 194. 07 194.02 07952 OTHER NON-REI M 0 0 0 0 0 148, 272 42, 201 194. 02 194.03 07953 MARKETING 134, 344 12, 035 1, 893 148, 272 42, 201 194. 02 194.04 077954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 0 0 0 194. 03 194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 0 0 00								
SUBTOTALS SUBTOTALS SUB of LINES 1 through 117) 9, 203, 957 438, 883 447, 025 9, 098, 938 2, 008, 035 118. 00 NONRE I MBURSABLE COST CENTERS 0 0 28, 361 8, 072 190. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 28, 361 0 0 0 0 194. 00 <	93.99		275, 672	13, 168	15, 77	304, 614	86, 700	93.99
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP CANTEEN 28, 361 0 0 28, 361 8, 072 190.00 194.00 07950 EAP 0 0 0 0 0 0 194.00 194.01 07950 EAP 0 0 0 0 0 0 0 0 194.00 194.01 07950 EAP 0 194.02 07952 0THER NON-REI M 0 0 0 0 0 0 0 0 0 194.02 07953 MARKETI NG 134, 344 12, 035 1, 893 148, 272 42, 201 194.02 200.00 0 0 0 0								
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28, 361 0 0 28, 361 8, 072 190.00 194.00 07950 EAP 0 0 0 0 0 194.00 194.01 07951 FAI RBANKS I NSTI TUTE 951, 732 61, 530 29, 561 1, 042, 823 296, 810 194.07 194.02 07952 OTHER NON-REI M 0 0 0 0 194.02 194.03 07953 MARKETI NG 134, 344 12, 035 1, 893 148, 272 42, 201 194.02 194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 0 200.00 0 0 201.00 0 0 201.00 0 0 0 0 0 0 0 0 201.00 0 0 201.00	118.00		9, 203, 957	438, 883	447, 02	9, 098, 938	2, 008, 035	118.00
194.00 07950 EAP 0 0 0 0 194.00 194.01 07951 FAI RBANKS INSTITUTE 951,732 61,530 29,561 1,042,823 296,810 194.00 194.02 07952 OTHER NON-REIM 0 0 0 0 194.00 194.03 07953 MARKETING 134,344 12,035 1,893 148,272 42,201 194.02 194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 0 0 0 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 0 0 0 0 0 0 0 0				_				
194.01 07951 FAI RBANKS INSTITUTE 951,732 61,530 29,561 1,042,823 296,810 194.02 194.02 07952 OTHER NON-REIM 0 0 0 0 194.02 194.03 07953 MARKETING 134,344 12,035 1,893 148,272 42,201 194.02 194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00								
194.02 07952 OTHER NON-REIM 0 0 0 194.02 194.03 07953 MARKETING 134,344 12,035 1,893 148,272 42,201 194.02 194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	Ű		0		
194.03 07953 MARKETING 134,344 12,035 1,893 148,272 42,201 194.02 194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00			951, 732	61, 530	29, 56	1, 042, 823		
194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY) 0 0 0 194.04 200.00 Cross Foot Adjustments 0 200.00 200.00 200.00 200.00 200.00 0 0 200.00 200.00 200.00 200.00 200.00 0 200.00 200.00 200.00 0 200.00			0	0		0 0		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0				12, 035	1, 89	148, 272		
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	0		0 0	0	•
						0		
202 UN LINEAL COM Lines 119 through 201) I 10 219 204I 512 449I 479 470I 10 210 204I 2 2EE 1101202 04				0		0 0		
202.00 101AL (Sum Thes the through 201) 10,316,394 312,446 476,479 10,318,394 2,335,118 202.00	202.00	TOTAL (sum lines 118 through 201)	10, 318, 394	512, 448	478, 47	10, 318, 394	2, 355, 118	202.00

Health Financial Systems	FAI RBA	ANKS		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2020 To 12/31/2020	8/2/2021 3:31	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	676, 423					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0				8.00
9.00 00900 HOUSEKEEPI NG	5, 635	0	435, 26			9.00
10. 00 01000 DI ETARY	114, 787	0	74, 48			10.00
11. 00 01100 CAFETERIA	0	0		0 0	129, 245	
16.00 01600 MEDI CAL RECORDS & LI BRARY	3, 659	0	2, 3	4 0	4, 916	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		-				
30. 00 03000 ADULTS & PEDI ATRI CS	349, 316				95, 383	•
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
ANCI LLARY SERVI CE COST CENTERS						54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	62, 628	0	40, 63		20, 282	90.00
90. 00 109000 CLINIC 93. 99 109399 PARTIAL HOSPITALIZATION PROGRAM	21, 315				20, 282	
SPECIAL PURPOSE COST CENTERS	21, 313	0	13,03		7,031	93.99
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	557, 340	0	357, 99	744, 601	128, 212	118 00
NONREI MBURSABLE COST CENTERS	337, 340	0	001,7	744,001	120, 212	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
194. 00 07950 EAP	0	0		0 0		194.00
194. 01 07951 FAI RBANKS I NSTI TUTE	99,601	0	64, 62	0		194.01
194. 02 07952 OTHER NON-RELM	0	0	01,01	0 0		194.02
194. 03 07953 MARKETI NG	19, 482	0	12, 64	1 0		194.03
194.04 07954 RECOVERY SCHOOL/(HOPE ACADEMY)	0	0	,-	0 0		194.04
200.00 Cross Foot Adjustments					-	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	676, 423	0	435, 26	744, 601	129, 245	202.00
				ан (* 1		

Heal th	Financial Systems	FAI RBAI	NKS		In Li	eu of Form CMS-2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Co & Post Stepdown Adjustments		
		16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
16.00	01600 MEDICAL RECORDS & LIBRARY	230, 777				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	169, 797	7, 269, 057		0 7, 269, 05	
33.00	03300 BURN INTENSIVE CARE UNIT	0)	0	0 33.00
	ANCI LLARY SERVICE COST CENTERS			1		
	05400 RADI OLOGY-DI AGNOSTI C	0	2,447		0 2,44	
	06000 LABORATORY	0	-311, 276		0 -311, 27	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	201, 122	2	0 201, 12	2 73.00
	OUTPATIENT SERVICE COST CENTERS			1		
	09000 CLI NI C	35, 879	933, 927		0 933, 92	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	25, 101	459, 192	2	0 459, 19	93.99
	SPECIAL PURPOSE COST CENTERS			1		
118.00		230, 777	8, 554, 469	2	0 8, 554, 46	9 118.00
	NONREI MBURSABLE COST CENTERS			1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36, 433	8	0 36, 43	
	07950 EAP	0	(D	0	0 194.00
	07951 FAI RBANKS I NSTI TUTE	0	1, 503, 863	8	0 1, 503, 86	
	07952 OTHER NON-REIM	0	(2	0	0 194.02
	07953 MARKETI NG	0	223, 629	2	0 223, 62	
	07954 RECOVERY SCHOOL/(HOPE ACADEMY)	0	(2	0	0 194.04
200.00			(2	0	0 200.00
201.00		0)	2	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	230, 777	10, 318, 394	ł	0 10, 318, 39	4 202.00

Heal th	Financial Systems	FAI RB/	ANKS		In Lie	eu of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS	1	Provider CC	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	_				_	
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	0	9, 408	9, 4(1.00 4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	68, 351	68, 3			1
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	0	16, 817	16, 81		4, 484	7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	0	0 3, 481	3, 48		-	1
9.00 10.00	01000 DI ETARY	0	70, 912	3, 40 70, 9'			10.00
10.00	01100 CAFETERIA	0	70, 912	70, 9	0 51	857	11.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	-	2, 20			16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	2,200	2,20	173	1,437	10.00
30, 00	03000 ADULTS & PEDIATRICS	0	215, 797	215, 79	97 4, 668	37, 666	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		215,7	0 0		33.00
55.00	ANCI LLARY SERVICE COST CENTERS	0	0			0	33.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	16	54.00
60.00	06000 LABORATORY	0			0 0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0 0		
	OUTPATIENT SERVICE COST CENTERS		-		-1 -	.,	
90.00	09000 CLINIC	0	38, 689	38, 68	39 831	5, 134	90.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0		13, 10	58 310	2, 594	93.99
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	438, 883	438, 88	33 8, 790	60, 070	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	241	190.00
194.00	07950 EAP	0	-		0 0	0	194.00
	07951 FAI RBANKS I NSTI TUTE	0	61, 530	61, 53	30 581		194.01
	07952 OTHER NON-REIM	0	0		0 0		194. 02
	07953 MARKETI NG	0	12, 035	12, 03	35 37		194.03
	07954 RECOVERY SCHOOL/(HOPE ACADEMY)	0	0		0 0	0	194.04
200.00					0		200.00
201.00			0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	512, 448	512, 44	18 9, 408	70, 454	202.00

Heal th Financial Systems FAI RBANKS In Lieu of Form CMS- ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0179 Period: Worksheet B From 07/01/2020 Part II	bared:
To 12/31/2020 Date/Time Pre 8/2/2021 3: 31	
Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA PLANT LINEN SERVICE DIETARY	
7.00 8.00 9.00 10.00 11.00	
GENERAL SERVICE COST CENTERS	
1.00 00100 CAP REL COSTS-BLDG & FIXT	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	5.00
7.00 00700 OPERATION OF PLANT 21,510	7.00
8.00 00800 LAUNDRY & LINEN SERVICE 0 0	8.00
9. 00 00900 HOUSEKEEPING 179 0 6, 815	9.00
10. 00 01000 DI ETARY 3, 650 0 1, 166 79, 547	10.00
11.00 01100 CAFETERIA 0 0 0 908	11.00
16. 00 01600 MEDI CAL_RECORDS & LI BRARY 116 0 37 0 35	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 11, 108 0 3, 549 79, 547 670	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0	33.00
ANCI LLARY SERVICE COST CENTERS	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0	54.00
60. 00 06000 LABORATORY 0 0 0 0 0	60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0	73.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 1, 992 0 636 0 142	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 678 0 217 0 54	93.99
SPECIAL PURPOSE COST CENTERS	
	118.00
NONREI MBURSABLE COST CENTERS	100.00
	190.00
	194.00
	194.01
	194.02
	194.03
	194.04
200.00 Cross Foot Adjustments	200.00
5	201.00
202.00 TOTAL (sum lines 118 through 201) 21,510 0 6,815 79,547 908	202.00

Heal th	Financial Systems	FAI RBAI	VKS		In Li	eu of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS			CN: 15-0179	Period: From 07/01/2020 To 12/31/2020	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Co & Post Stepdown Adjustments		
		16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS					
	00100 CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	00500 ADMINISTRATIVE & GENERAL					5.00
	00700 OPERATION OF PLANT					7.00
	00800 LAUNDRY & LINEN SERVICE					8.00
	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01600 MEDICAL RECORDS & LIBRARY	4, 078				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	3,000	356, 005	5	0 356, 00	
	03300 BURN INTENSIVE CARE UNIT	0	0)	0	33.00
	ANCI LLARY SERVICE COST CENTERS					
	05400 RADI OLOGY-DI AGNOSTI C	0	16	b l	0 1	54.00
	06000 LABORATORY	0	C	D	0	60.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 333	3	0 1, 33	3 73.00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	634	48, 058		0 48, 05	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	444	17, 465	ō	0 17, 46	5 93. 99
	SPECIAL PURPOSE COST CENTERS				-	
118.00		4,078	422, 877	7	0 422, 87	7 118.00
	NONREI MBURSABLE COST CENTERS	· · ·			- i	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	241		0 24	
	07950 EAP	0	C		0	D 194.00
	07951 FAI RBANKS I NSTI TUTE	0	75, 170	D	0 75, 17	
	07952 OTHER NON-REIM	0	C	1	0	D 194. 02
	07953 MARKETI NG	0	14, 160	D	0 14, 16	
	07954 RECOVERY SCHOOL/(HOPE ACADEMY)	0	C	D I	0	D 194. 04
200.00			C	D I	0	200.00
201.00		0	C	ן ע	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,078	512, 448	3	0 512, 44	B 202.00

	Financial Systems	FAI RBA			In Lie	u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Period:	Worksheet B-1	
					From 07/01/2020 To 12/31/2020	Date/Time Pre	narod
				· · · · · · · · · · · · · · · · · · ·	12/31/2020	8/2/2021 3: 31	nm
		CAPI TAL				0, 2, 2021 0101	
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
	·	(SQUARE FEET)	BENEFITS		& GENERAL	PLANT	
			DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS				
			SALARI ES)				
		1.00	4.00	5A	5.00	7.00	
	GENERAL SERVICE COST CENTERS	445.05/		1	1		1 1 00
	00100 CAP REL COSTS-BLDG & FIXT	115, 856					1.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT	2, 127	6, 648, 747				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	15, 453	1, 485, 966			o	5.00
7.00	00700 OPERATION OF PLANT	3, 802	147, 924			94, 474	
	00800 LAUNDRY & LINEN SERVICE	0			-	0	
9.00	00900 HOUSEKEEPI NG	787	217, 253		334, 437	787	9.00
	01000 DI ETARY	16, 032	97, 783			16, 032	
	01100 CAFETERIA	0	35, 774			0	
	01600 MEDICAL RECORDS & LIBRARY	511	122, 007	(0 171, 123	511	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	(0.700)		J		10.700	
	03000 ADULTS & PEDIATRICS	48, 788	3, 298, 342			48, 788	
33.00	03300 BURN INTENSIVE CARE UNIT	0	C) ()	0 0	0	33.00
F 4 00	ANCI LLARY SERVICE COST CENTERS				4 005		54.00
	05400 RADI OLOGY-DI AGNOSTI C	0	C		.,	0	
	06000 LABORATORY	0	C			0	
	07300 DRUGS CHARGED TO PATIENTS	0	C) (156, 561	0	73.00
	OUTPATIENT SERVICE COST CENTERS	0 747	E07 442		(02.001	0 747	90.00
	09399 PARTIAL HOSPITALIZATION PROGRAM	8, 747 2, 977	587, 442 219, 188			8, 747 2, 977	
93.99	SPECIAL PURPOSE COST CENTERS	2,911	219, 188		304, 614	2,911	93.99
118.00		99, 224	6, 211, 679	-2, 043, 842	2 7, 055, 096	77 012	118.00
110.00	NONREI MBURSABLE COST CENTERS	77, 224	0,211,079	-2,043,042	7,055,090	77,042	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		28, 361	0	190.00
	07950 EAP	0					194.00
	07951 FAI RBANKS I NSTI TUTE	13, 911	410, 768		-		194.00
	07952 OTHER NON-REIM	13, 711	410,700		1, 042, 023		194.02
	07953 MARKETI NG	2, 721	26, 300		148, 272		194.02
	07954 RECOVERY SCHOOL/(HOPE ACADEMY)	2,721	20, 300		0 140, 272		194.03
200.00		0	C			0	200.00
200.00	Negative Cost Centers						200.00
201.00	Cost to be allocated (per Wkst. B,	512, 448	478, 479		2, 355, 118	676, 423	
202.00	Part I)	512, 740	770, 475		2, 333, 110	070, 423	
203.00	Unit cost multiplier (Wkst. B, Part I)	4, 423146	0.071965		0. 284622	7. 159885	203.00
204.00	Cost to be allocated (per Wkst. B,		9, 408		70, 454		204.00
	Part II)		., 100		, 101	,010	
205.00	Unit cost multiplier (Wkst. B, Part		0.001415	5	0.008515	0. 227682	205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)			1			
		1			1		1
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems		FAI RBA	ANKS		In Lie	u of Form CMS-3	2552-10
COST ALLOCATION - STATISTICAL BASI	S		Provider C	CN: 15-0179	Peri od:	Worksheet B-1	
					From 07/01/2020		
					To 12/31/2020	Date/Time Pre 8/2/2021 3:31	
Cost Center Descriptio	n	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERI A	MEDI CAL	
	11	LINEN SERVICE	(SQUARE FEET)			RECORDS &	
		(100% ALLOC	(520/112 1221)		(1123)	LIBRARY	
		ATI ON)				(GROSS CHAR	
						GES)	
		8.00	9.00	10.00	11.00	16.00	
GENERAL SERVICE COST CENTERS	5						
1.00 00100 CAP REL COSTS-BLDG & F	IXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPA	RTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENER	AL						5.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVIC	E	0					8.00
9. 00 00900 HOUSEKEEPI NG		0	93, 687				9.00
10. 00 01000 DI ETARY		0	16, 032	12, 57	9		10.00
11. 00 01100 CAFETERI A		0	0		0 136, 076		11.00
16.00 01600 MEDICAL RECORDS & LIBR	ARY	0	511		0 5, 176	15, 339, 467	16.00
INPATIENT ROUTINE SERVICE CO	OST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS		0	48, 788	12, 57	9 100, 424	11, 286, 279	30.00
33.00 03300 BURN INTENSIVE CARE UN		0	0		0 0	0	33.00
ANCILLARY SERVICE COST CENTE	RS						
54.00 05400 RADI OLOGY-DI AGNOSTI C		0	0		0 0	0	54.00
60. 00 06000 LABORATORY		0	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIE		0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENT	ERS						
90. 00 09000 CLINIC		0	8, 747		0 21, 354	2, 384, 776	90.00
93. 99 09399 PARTI AL HOSPI TALI ZATI O		0	2, 977		0 8, 034	1, 668, 412	93.99
SPECIAL PURPOSE COST CENTERS					-		
118.00 SUBTOTALS (SUM OF LINE		0	77, 055	12, 57	9 134, 988	15, 339, 467	118.00
NONREI MBURSABLE COST CENTERS				1			
190.00 19000 GIFT, FLOWER, COFFEE S	HOP & CANTEEN	0	0		0 0		190. 00
194.0007950 EAP		0	0		0 0	-	194.00
194. 01 07951 FAI RBANKS I NSTI TUTE		0	13, 911		0 0		194.01
194.0207952 OTHER NON-REIM		0	0		0 0		194.02
194. 03 07953 MARKETI NG		0	2, 721		0 1, 088		194.03
194.04 07954 RECOVERY SCHOOL/(HOPE		0	0		0 0	0	194.04
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers			105 0/0				201.00
202.00 Cost to be allocated (per Wkst. B,	0	435, 260	744, 60	1 129, 245	230, 777	202.00
Part I)		0.000000	4 (45005	F0 10007	0.040000	0.015045	202.02
203.00 Unit cost multiplier (0. 000000	4. 645895			0. 015045	
204.00 Cost to be allocated (per WKST. B,	0	6, 815	79, 54	7 908	4,078	204.00
Part II)	What D Dant	0,00000	0 070740	(22270	0.00(772	0.000244	205 00
205.00 Unit cost multiplier (WKSL B, Part	0. 000000	0. 072742	6. 32379	4 0. 006673	0. 000266	205.00
206.00 NAHE adjustment amount	to be all conted						206.00
(per Wkst. B-2)							200.00
207.00 NAHE unit cost multipl	ier (Wkst D						207.00
Parts III and IV)							207.00
	I	I		I	1		I

Health Financial Systems	FAI RBA	ANKS		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 269, 057		7, 269, 0	57 0	7, 269, 057	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33.00
ANCI LLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2,447		2, 44	47 0	2, 447	54.00
60. 00 06000 LABORATORY	0			0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	201, 122		201, 12	22 0	201, 122	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	933, 927		933, 92	27 0	933, 927	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	459, 192		459, 19	92 0	459, 192	93.99
200.00 Subtotal (see instructions)	8, 865, 745	0	8, 865, 74	45 0	8, 865, 745	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	8, 865, 745	0	8, 865, 74	45 0	8, 865, 745	202.00

Health Financial Systems	FAI RBA	NKS		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Title	e XVIII	Hospi tal	PPS	
		Charges	_			
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	11, 286, 279		11, 286, 27	19		30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0		33.00
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0.000000	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 0.000000	0.00000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	2, 384, 776	2, 384, 7	0. 391620	0.00000	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	1, 668, 412	1, 668, 4	2 0. 275227	0. 000000	93.99
200.00 Subtotal (see instructions)	11, 286, 279	4, 053, 188				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	11, 286, 279	4, 053, 188	15, 339, 46	57		202.00

Heal th	ealth Financial Systems FAIRBANKS In Lie					
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 8/2/2021 3:31	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
33.00	03300 BURN INTENSIVE CARE UNIT					33.00
	ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 391620				90.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 275227				93.99
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	FAI RBA	ANKS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 269, 057		7, 269, 0	57 0	7, 269, 057	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33.00
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 447		2, 4	47 0	2, 447	54.00
60. 00 06000 LABORATORY	0			0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	201, 122		201, 1	22 0	201, 122	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	933, 927		933, 9	27 0	933, 927	90.00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	459, 192		459, 1	92 0	459, 192	93.99
200.00 Subtotal (see instructions)	8, 865, 745	0	8, 865, 7	45 0	8, 865, 745	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	8, 865, 745	0	8, 865, 7	45 0	8, 865, 745	202.00

Health Financial Systems	FAI RBA	NKS		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 286, 279		11, 286, 2	19		30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0		33.00
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0.000000	0. 000000	54.00
60.00 06000 LABORATORY	0	0		0 0.000000	0. 000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	2, 384, 776	2, 384, 7	0. 391620	0. 000000	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	1, 668, 412	1, 668, 4	2 0. 275227	0.00000	93.99
200.00 Subtotal (see instructions)	11, 286, 279	4, 053, 188	15, 339, 40	57		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	11, 286, 279	4, 053, 188	15, 339, 40	57		202.00

Health Financial Systems	FAI RBAN	IKS	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0179	Peri od: From 07/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 8/2/2021 3:31	epared: pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
ANCI LLARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000				93.99
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	Health Financial Systems FAIRBANKS				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0179		Worksheet D Part I	
				From 07/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	356, 005	0	356, 00	6, 274	56.74	30.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
200.00 Total (lines 30 through 199)	356, 005		356, 00	6, 274		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDIATRICS	259	14, 696				30.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
200.00 Total (lines 30 through 199)	259	14, 696				200. 00

Health Financial Systems	FAI RB/	ANKS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider CO	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ co	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	16	0	0.0000	0 00	0	54.00
60. 00 06000 LABORATORY	0	0	0.0000	0 00	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 333	0	0.0000	0 00	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	48, 058	2, 384, 776	0. 0201	52 0	0	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	17, 465	1, 668, 412	0.0104	68 0	0	93.99
200.00 Total (lines 50 through 199)	66, 872	4, 053, 188		0	0	200. 00

Health Financial Systems	FAI RBA			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COST			Period: From 07/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:31	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Healt	h Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
'	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 27	4 0.00	259	30.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0 0.00	0	33.00
200.00 Total (lines 30 through 199)		0	6, 27	4	259	200.00
Cost Center Description	I npati ent		· · ·	-	•	
'	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	FAI RBA	ANKS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 12/31/2020		oared.
				12, 01, 2020	8/2/2021 3: 31	pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		o o	0	93.99
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	FAI RBA	NKS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0179	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
				To 12/31/2020	Date/Time Pre 8/2/2021 3:31	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS			1			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 0	0. 000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 2, 384, 776	0.000000	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 1, 668, 412	0.000000	93.99
200.00 Total (lines 50 through 199)	0	0		0 4, 053, 188		200. 00

Health Financial Systems	FAI RBAN	<s< th=""><th></th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></s<>		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0179	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 12/31/2020		pared:
					8/2/2021 3:31	pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	· ·					1
90. 00 09000 CLINIC	0. 000000	0		0 7,851	0	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0 79, 348	0	93.99
200.00 Total (lines 50 through 199)		0		0 87, 199	0	200. 00

Health Financial Systems	FAI RB/	ANKS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Services (see inst.)		Cost Reimbursed Services Not Subject To	PPS Services (see inst.)	
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 391620	7, 851		0 0	3, 075	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 275227	79, 348		0 0	21, 839	93.99
200.00 Subtotal (see instructions)		87, 199		0 0	24, 914	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)	[87, 199		0 0	24, 914	202.00

Heal th	Financial Systems	FAI RB	ANKS		In Lie	u of Form CMS-	2552-10
APPORT	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0179	Peri od: From 07/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 8/2/2021 3:31	
				XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	1					
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	06000 LABORATORY	0	0				60.00
	07300 DRUGS CHARGED TO PATIENTS	0	0)			73.00
	OUTPATIENT SERVICE COST CENTERS		1				_
	09000 CLI NI C	0	0				90.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0				93.99
200.00	Subtotal (see instructions)	0	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	FAI RBA	ANKS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Services (see inst.)		Cost Reimbursed Services Not Subject To	PPS Services (see inst.)	
			Ded. & Coins	. Ded. & Coins.		
	1.00		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000					54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			0 0	0	
60. 00 06000 LABORATORY	0. 000000			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 391620			0 0	0	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 275227	0	68	37 0	0	93.99
200.00 Subtotal (see instructions)		0	68	37 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)		0	68	37 0	0	202.00

Health Financial Systems	FAI RB	ANKS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider CO	CN: 15-0179	Peri od: From 07/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 8/2/2021 3:31	
		Ti tl	e XIX	Hospi tal	Cost	
	Co	sts				
Cost Center Description	Cost Reimbursed Services	Cost Reimbursed Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	189	0				93.99
200.00 Subtotal (see instructions)	189	0				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	189	0				202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0179	Period: From 07/01/2020	Worksheet D-1	
			To 12/31/2020	Date/Time Prep 8/2/2021 3:31	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(c. oveluding nowbern)		6, 274	
00	Inpatient days (including private room days, excluding swing-bed day Inpatient days (including private room days, excluding swing-			6, 274	
00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	
00	do not complete this line.			()74	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	6, 274 0	4
00	reporting period	in days) through become	i of the cost	0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	m days) through December	31 of the cost	0	-
00	reporting period	in days) through becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	1 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	a the Dreaman (avaluding	owing bod and	25.0	9
00	newborn days) (see instructions)	the Program (excruding	swing-bed and	259	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	1
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period			_	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)		3 /	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	1 17
. 00	reporting period	thi bugh becember of e		0.00	''
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period	C			
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	is)		7, 269, 057	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	a partial (line (0	23
. 00	x line 18)	ST OF THE COST TEPOLITY	ig period (Trite o	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
00	7 x line 19)	21 of the east reporting	noried (line 0	0	2
. 00	Swing-bed cost applicable to NF type services after December x line 20)	si or the cost reporting		0	25
. 00	Total swing-bed cost (see instructions)			0	
1	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 269, 057	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)		lar geo)	0	29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost pet of swing-bed cost	and private room cost di	fforontial (line	0 7 269 057	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di		7, 269, 057	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 450 15	
. 00 . 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 158. 60 300, 077	
	Medically necessary private room cost applicable to the Progr				40
	Total Program general inpatient routine service cost (line 39	•		300, 077	

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0179	Period: From 07/01/2020	Worksheet D-1	1
					To 12/31/2020		
			Titl	e XVIII	Hospi tal	PPS	- pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)						42
00	Intensive Care Type Inpatient Hospital Units						- 40
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43
. 00	BURN INTENSIVE CARE UNIT	0	(o.	00 0	0	
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	Line 200)			1.00) 48
. 00	Total Program inpatient costs (sum of lines			ons)		300, 077	
	PASS THROUGH COST ADJUSTMENTS					I	
. 00	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, su	m of Parts I and	14, 696	50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	v services (fi	com Wkst D	sum of Parts II	C	51
	and IV)		, (1000 (11				
. 00	Total Program excludable cost (sum of lines					14, 696	
8. 00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anest	hetist, and	285, 381	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				I	
. 00	Program di scharges					C	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (ine 56 minus	line 53)		
. 00 . 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1996. i	updated and c	ompounded by the	-	
	market basket						
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					C) 61
	amount (line 56), otherwise enter zero (see		3 (111163 54 X	00), 01 1% 0	i the target		
. 00	Relief payment (see instructions)					c c	
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			C) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	C	64
. 00	instructions) (title XVIII only)	ts through beech			ing period (see		104
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reportin	g period (See	C	65
00	instructions) (title XVIII only)	na aaata (lina	(1 plug lipg	(E) (+; + - V)/			
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (inne	64 prus rine (bb)(title XVI	ri oniy). For	C) 66
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	c c	67
	(line 12 x line 19)	0					
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	C	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	- 68)		C	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N			,			
. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine serv						74
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
~~	26, line 45)	2)					
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79
00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem limi		\ \				81
. 00 . 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82
. 00	Program inpatient ancillary services (see in		-,				84
. 00	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
00	Total abconvation had days (ass instructions)					
7.00 8.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0. 00	

Health Financial Systems	FAI RBA	ANKS		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2020 To 12/31/2020		pared: pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	356, 005	7, 269, 057	0. 04897	5 0	0	90.00
91.00 Nursing School cost	0	7, 269, 057	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	7, 269, 057	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 269, 057	0.00000	o o	0	93.00

	Financial Systems ATION OF INPATIENT OPERATING COST	FAI RBANKS Provi der CCN: 15-0179	Period: From 07/01/2020	u of Form CMS-2 Worksheet D-1	
			To 12/31/2020	Date/Time Prep 8/2/2021 3:31	
	Cost Center Description	Title XIX	Hospi tal	Cost	1
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
. 00	Inpatient days (including private room days and swing	-bed days, excluding newborn)		6, 274	1 1.
. 00	Inpatient days (including private room days, excluding			6, 274	
. 00	Private room days (excluding swing-bed and observation do not complete this line.	n bed days). If you have only pr	rivate room days,	0	3.
. 00	Semi-private room days (excluding swing-bed and observ	vation bed days)		6, 274	4
. 00	Total swing-bed SNF type inpatient days (including pr		er 31 of the cost	0	5
. 00	reporting period Total swing-bed SNF type inpatient days (including pr	ivata room dave) after December	21 of the cost	0	6
. 00	reporting period (if calendar year, enter 0 on this I	ine)	ST OF THE COST	0	0
. 00	Total swing-bed NF type inpatient days (including pri-		⁻ 31 of the cost	0	7
00	reporting period				
. 00	Total swing-bed NF type inpatient days (including pri- reporting period (if calendar year, enter 0 on this I		si of the cost	0	8
. 00	Total inpatient days including private room days appl		g swing-bed and	283	9
	newborn days) (see instructions)				1 4 0
0.00	Swing-bed SNF type inpatient days applicable to title through December 31 of the cost reporting period (see		room days)	0	10
1.00	Swing-bed SNF type inpatient days applicable to title		room days) after	0	11
	December 31 of the cost reporting period (if calendar				
2.00	Swing-bed NF type inpatient days applicable to titles through December 31 of the cost reporting period	v or XIX only (Including privat	te room days)	0	12
3.00	Swing-bed NF type inpatient days applicable to titles	V or XIX only (including privation	te room days)	0	13
	after December 31 of the cost reporting period (if ca				
4.00 5.00	Medically necessary private room days applicable to t Total nursery days (title V or XIX only)	he Program (excluding swing-bed	days)	0	14
6.00	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to	o services through December 31 d	of the cost	0.00	17
8.00	reporting period Medicare rate for swing-bed SNF services applicable to	o services after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to	services through December 31 of	f the cost	0.00	19
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to	services after December 31 of t	the cost	0.00	20
	reporting period				
1.00	Total general inpatient routine service cost (see ins			7, 269, 057	
2.00	Swing-bed cost applicable to SNF type services through 5×1 (ine 17)	n December 31 of the cost report	ting period (line	0	22
3.00	Swing-bed cost applicable to SNF type services after	December 31 of the cost reportin	ng period (line 6	0	23
	x line 18)				
4.00	Swing-bed cost applicable to NF type services through 7×1 ine 19)	December 31 of the cost report	ng period (line	0	24
5.00	Swing-bed cost applicable to NF type services after D	ecember 31 of the cost reporting	g period (line 8	0	25
	x line 20)				
6.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-b	ed cost (line 21 minus line 26)		0 7, 269, 057	26
7.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			1,207,037	2'
	General inpatient routine service charges (excluding	swing-bed and observation bed ch	narges)	0	
9.00				0	
0. 00 1. 00	Semi-private room charges (excluding swing-bed charges General inpatient routine service cost/charge ratio (0 0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line			0.00	
3.00	Average semi-private room per diem charge (line 30 ÷			0.00	
4.00 5.00	Average per diem private room charge differential (li Average per diem private room cost differential (line		CTIONS)	0. 00 0. 00	
6. 00	Private room cost differential adjustment (line 3 x l			0.00	
7.00	General inpatient routine service cost net of swing-b		fferential (line	7, 269, 057	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH (COST ADJUSTMENTS			1
	Adjusted general inpatient routine service cost per d			1, 158. 60	38
8.00	···· J == • • • · · · · · · · · · · · · · · ·	(
9.00	Program general inpatient routine service cost (line Medically necessary private room cost applicable to t	9 x line 38)		327, 884 0	

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0179	Period: From 07/01/2020		
					To 12/31/2020	Date/Time Pre 8/2/2021 3:37	
	Cast Contor Description	Total		e XIX	Hospital	Cost	
	Cost Center Description	Total Inpatient Costl		Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	_
. 00	NURSERY (title V & XIX only)						42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1		[43
. 00	CORONARY CARE UNIT						43
. 00	BURN I NTENSI VE CARE UNI T	0	C	0.	00 0	C	
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			0) 48
. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ns)		327, 884	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	ationt routing (sonuloos (from		m of Dorte L and		50
. 00	<pre>[Pass through costs appricable to Program thp [111]</pre>			IWKSL. D, SU			50
. 00	Pass through costs applicable to Program inp	atient ancillary	y services (fr	om Wkst. D,	sum of Parts II	0	51
00	and IV)	FO and F1					
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-nhy	sician anest	hatist and		
. 50	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
. 00	Program di scharges					0	
. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and tar	rget amount (l	ine 56 minus	Line 53)		
. 00	Bonus payment (see instructions)		g			C	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, ι	pdated and c	ompounded by the	0.00	59
00	market basket	cost coport up	hatad by the m	arkat backat		0.00	60
. 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			Ū.		
. 00	Relief payment (see instructions)	opt (coo instru	ations)				
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST						1 03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost report	ing period (See	0	64
	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	g period (See	C) 65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line é	64 plus line 6	5)(title XVI	ll onlv). For	0	66
	CAH (see instructions)			-,(
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	C	67
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost ren	orting period	0	68
. 00	(line 13 x line 20)			the cost rep	bitting period		
. 00	Total title V or XIX swing-bed NF inpatient			,		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N				<u>\</u>		
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70
. 00	Program routine service cost (line 9 x line			2)			72
. 00	Medically necessary private room cost applic	able to Program	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	,					78
. 00	Aggregate charges to beneficiaries for exces	• •		· · · · · · · · · · · · · · · · · · ·	nuc line 70)		79
. 00 . 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		ost i i mitati or	ι (IIIe /ၓ MI	nus i ne 79)		80
. 00	Inpatient routine service cost per drem rimi)				82
. 00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation	•					85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ougn 85)			1	86
. 00	Total observation bed days (see instructions					C	87
			1: 2)			0.00	
. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		Tine 2)			0.00	89

Health Financial Systems	FAI RBA	ANKS		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2020 To 12/31/2020		pared: pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(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	356, 005	7, 269, 057	0. 04897	5 0	0	90.00
91.00 Nursing School cost	0	7, 269, 057	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 269, 057	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 269, 057	0. 00000	0 0	0	93.00

Heal th Financ	sial Systems	FAI RBANKS		In Lie	u of Form CMS-2	2552-10
INPATIENT AND	CILLARY SERVICE COST APPORTIONMENT	Provider C	CCN: 15-0179	Period:	Worksheet D-3	
				From 07/01/2020 To 12/31/2020		pared: pm
		Titl	e XVIII	Hospi tal	PPS	
(Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS			553, 546		30.00
33.00 03300 E	BURN INTENSIVE CARE UNIT			0		33.00
ANCI LL	ARY SERVICE COST CENTERS					
54.00 05400 F	RADI OLOGY-DI AGNOSTI C		0.0000	0 00	0	54.00
60.00 06000 L	LABORATORY		0.0000	0 00	0	60.00
73.00 07300 [DRUGS CHARGED TO PATIENTS		0.0000	0 00	0	73.00
OUTPAT	IENT SERVICE COST CENTERS		·			1
90.00 09000 0	CLINIC		0. 3916	20 0	0	90.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM		0. 2752	27 0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through	n 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only	y charges (line 61)		0		201.00
	Net charges (line 200 minus line 201)			0		202.00
1 1				I .		•

Health Fina	ncial Systems	FAI RBANKS		In Lie	u of Form CMS-:	2552-10
INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0179	Period:	Worksheet D-3	
				From 07/01/2020 To 12/31/2020		pared: pm
		Tit	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	0 ADULTS & PEDIATRICS			553, 546		30.00
33.00 0330	OBURN INTENSIVE CARE UNIT			0		33.00
ANCI	LLARY SERVICE COST CENTERS					
54.00 0540	0 RADI OLOGY-DI AGNOSTI C		0.0000	0 00	0	54.00
60.00 0600	0 LABORATORY		0.0000	0 00	0	60.00
73.00 0730	0 DRUGS CHARGED TO PATIENTS		0.0000	0 00	0	73.00
OUTP	ATIENT SERVICE COST CENTERS					
90.00 0900			0. 3916	20 0	0	90.00
93.99 0939	9 PARTIAL HOSPITALIZATION PROGRAM		0. 2752	27 0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 throug	h 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program onl	y charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			0		202.00
			•			

Heal th	Financial Systems FA	I RBANKS	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	
				1.00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges (instructions)	occurring prior to October 1	(see	0 256, 285	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges (instructions)	occurring on or after October	1 (see	173, 046	1.02
1.03	DRG for federal specific operating payment for Model 4 I 1 (see instructions)	BPCI for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 I October 1 (see instructions)	BPCI for discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see in:	structions)		0	2.01 2.02
2.02	Outlier payments for discharges occurring prior to Octol	-		0	2.02
2.00	Outlier payments for discharges occurring on or after O	. , ,		0	2.04
3.00	Managed Care Simulated Payments	,		0	3.00
4.00	Bed days available divided by number of days in the cos	t reporting period (see instru	uctions)	86.00	4.00
5.00	Indirect Medical Education Adjustment FTE count for all opathic and osteopathic programs for the	he most recent cost reporting	period ending on	0.00	5.00
6.00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that r new programs in accordance with 42 CFR 413.79(e)	meet the criteria for an add-	on to the cap for	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as speci			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified cost report straddles July 1, 2011 then see instructions	S.	, , , , , ,	0.00	
8.00	Adjustment (increase or decrease) to the FTE count for a affiliated programs in accordance with 42 CFR 413.75(b), 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE (report straddles July 1, 2011, see instructions.	cap slots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE ounder § 5506 of ACA. (see instructions)	cap slots from a closed teach	ng hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minu instructions) $% \left(\frac{1}{2}\right) =0$		•	0.00	9.00
10.00 11.00	FTE count for allopathic and osteopathic programs in the FTE count for residents in dental and podiatric programs	5 5	rds	0.00 0.00	
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	
14.00	Total allowable FTE count for the penultimate year if the otherwise enter zero.	hat year ended on or after Se	otember 30, 1997,	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program	m		0.00	16.00
17.00	Adjustment for residents displaced by program or hospita	al closure		0.00	17.00
18.00	Adjusted rolling average FTE count				18.00
19.00	Current year resident to bed ratio (line 18 divided by)	line 4).		0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21.00 22.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000 0	21.00
	IME payment adjustment - Managed Care (see instructions))		0	22.00
23.00	Indirect Medical Education Adjustment for the Add-on for Number of additional allopathic and osteopathic IME FTE	r§422 of the MMA	CER 412 105	0.00	
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	
24.00 25.00	If the amount on line 24 is greater than -0-, then enter instructions)	r the lower of line 23 or line	e 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)			0	
28.01	IME add-on adjustment amount - Managed Care (see instruc	ctions)		0	28.01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and	d 28.01)		0	29.00 29.01
_ / . 0 .	Di sproporti onate Share Adj ustment			0	
30.00	Percentage of SSI recipient patient days to Medicare Pa	rt A patient days (see instru	ctions)	14.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)			4.51	
32.00	Sum of lines 30 and 31			19. 18	
33.00	Allowable disproportionate share percentage (see instruc	ctions)			33.00
21 00	Disproportionate share adjustment (see instructions)			5,603	34.00

	Financial Systems FAI RBA			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 07/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		8, 350, 599, 096	8, 290, 014, 521	35.00
35.01	Factor 3 (see instructions)		0. 000069353	0. 000052888	35.01
35. 02	Hospital uncompensated care payment (If line 34 is zero, en instructions)	ter zero on this line) (see	579, 135	438, 440	35. 02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35		145, 575 256, 086		35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary (
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, instructions)	684 and 685. (see	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	S-DRGs 652, 682, 683, 684	0		41.01
42.00 43.00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42.00 43.00
44.00	instructions) Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0. 000000		44.00
45.00	days) Average weekly cost for dialysis treatments (see instructio	ns)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line	41.01)	0		46.00
47.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	amall numal beanitals	691, 020 0		47.00
48.00	only. (see instructions)	smart fural nospitars	0		48.00
				Amount	
49.00	Total payment for inpatient operating costs (see instructio	nc)		1.00 691,020	49.00
49.00 50.00	Payment for inpatient program capital (from Wkst. L, Pt. I			34, 666	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0 1/ 000	
52.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	60)		0	54. 01 55. 00
56.00	Cost of physicians' services in a teaching hospital (see in			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		rouah 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt		5	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			725, 686	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 min	us line 60)		725, 686	
62.00	Deductibles billed to program beneficiaries			60, 544	
63.00	Coinsurance billed to program beneficiaries			0	
64.00 65.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
66.00	Allowable bad debts for dual eligible beneficiaries (see in	etructione)		0	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	311 4611 013)		665, 142	
68.00	Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (see	e instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demon		nstructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestratio	n		0	70.87
	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.88	Pioneer ACO demonstration payment adjustment amount (see in	structions)			70. 89 70. 90
70.89					
70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 89 70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 89 70. 90 70. 91 70. 92	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92
70. 89 70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91

Title XVIII	Peri od:	worksheet E	2002
FPY 70. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 70. 71 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 70. 72 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 70. 84 Low Volume Payment -3 71. 05 Demonstration payment adjustment amount after sequestration 11. 05 71. 05 Demonstration payment adjustment amount after sequestration 11. 03 72. 00 Interrin payments: 21. 01 73. 01 Tentative settlement -PARHM (see instructions) 73. 01 74. 01 Balance due provider/programPARHM (see instructions) 75. 00 75. 00 Protested amounts (nonal lowable cost report items) in accordance with 048 Pub. 15-2, chapter 1, \$115.2 70. 86 CoMPLETED BY COMTRACTOR (Lines 90 through 96) 70. 00 Operating outlier reconciliation adjustment amount (see instructions) 74. 01 73. 01 English outlier from Wsst. L, Pt. I., line 2 74. 01 Bayes and the me value of money for operating expenses (see instructions) 75. 00 76. 00 Time value of money for operating expenses (see i	From 07/01/2020 To 12/31/2020	Part A	
FPY 0.96 Low volume adjustment for federal fiscal year (ypyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 0.97 Low volume adjustment for federal fiscal year (ypyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0.97 Low volume adjustment for federal fiscal year (ypyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0.98 Low volume Payment -3 0.99 HC adjustment See instructions) 1.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 1.01 Sequestration adjustment 2RARM pass-throughs 2.00 Interim payments 2.01 Interim payments 2.01 Interim payments 2.03 Interim payments 3.00 Tentative settlement (For contractor use only) 3.01 Tentative settlement-PARM (for contractor use only) 3.02 Completion (Lines 90 through 96) 0 Operating outiler reconciliation adjustment amount (see instructions) 1.00 Capital outiler from Wkst. L, Pt. I., line 2 2.00 Operating outiler reconciliation adjustment amount (see instructions) 3.00 Capit	Hospi tal	PPS	рш
0.6 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 0.7 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0.8 Low volume Payment-3 0.99 HAC adjustment (ine 67 minus lines 68 plus/minus lines 69 ± 70) 0.90 Round the provider (line 67 minus lines 68 plus/minus lines 69 ± 70) 1.01 Sequestration adjustment adjustment anount after sequestration 1.02 Benonstration payments adjustment anount after sequestration 1.03 Sequestration adjustment (for contractor use only) 3.01 Tentative settlement/PARMM (for contractor use only) 3.01 Tentative settlement (for contractor use only) 3.01 Tentative settlement (for contractor use only) 3.01 Tentative settlement (for contractor use only) 3.01 Deproxider/program-PARMM (see instructions) 0.02 Operating outlier reconciliation adjustment amount (see instructions) 1.03 Equital outlier reconciliation adjustment amount (see instructions) 3.00 Capital outlier reconciliation adjustment amount (see instructions) 3.00 Tentative settlement for HS	(уууу)	Amount	
the corresponding federal year for the period prior to 10/1) 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0.88 Low Volume Payment-3 0.99 HAC adjustment amount (see instructions) 1.01 Sequestration adjustment (see instructions) 1.02 Beomostration payment adjustment amount after sequestration 1.03 Sequestration adjustment (see instructions) 1.01 Sequestration adjustment amount after sequestration 1.02 Demonstration payments adjustment amount after sequestration 1.03 Sequestration adjustment (for contractor use only) 1.01 Tentative settlement (for contractor use only) 1.01 Tentative settlement (for contractor use only) 1.01 Tentative settlement (for contractor use only) 1.02 Demonstration payments 2.01 Interim payments 2.01 Operating outlier consolicition adjustment amount (see instructions) 3.00 Capital outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 2.01 Operating outlier reconciliation adjustment amount (see instructions) 3.00 Capital outlier reconciliation adjustment amount (see instructions) 3.00 Capital outlier colculate the time value of money (see instructions) 4.00 HSP Bonus amount (see instructions) 4.00 HSP Adjustment factor (see instructions) 5.00 Ca	0	1.00	
 1.07 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0) the corresponding federal year for the period ending on or after 10/1) 0.78 Low Volume Payment-3 0.79 HAC adjustment see instructions) 1.00 Anount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 1.05 Equestration adjustment (see instructions) 1.00 Demonstration payment adjustment amount after sequestration 1.01 Sequestration adjustment (reconstructions) 1.02 Demonstration payments. 2.01 Interim payments. 2.02 Interim payments. 2.03 Interim payments. 2.04 (see instructions) 2.00 Operating outlier reconciliation adjustment amount (see instructions) 3.01 The value of money for operating expenses (see instructions) 3.02 The value of money for capital related expenses (see instructions) 3.00 Time value of money for separating expenses. 3.00 The value of money for HSP Bon	0	0	70.
 the corresponding federal year for the period ending on or after 10/1) 94 but Wolume Payment-3 95 HAC adjustment amount (see instructions) 05 Aguestration adjustment (line 67 minus lines 68 plus/minus lines 69 % 70) 101 Sequestration adjustment (see instructions) 102 Demonstration payment adjustment mount after sequestration 103 Sequestration adjustment-PARHM pass-throughs 101 Interim payments 101 Interim payments 102 Interim payments (for contractor use only) 101 Tentative settlement (for contractor use only) 101 Tentative settlement (for contractor use only) 101 Tentative settlement (for contractor use only) 102 Balance due provider/program-PARHM (see instructions) 103 Portested amounts (nonallowable cost report ltems) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 103 EGUPLETED BV CONTRACTOR (lines 90 through 96) 104 Operating outlier amount from Wkst. E, Pt. A. line 2, or sum of 2.03 plus 2.04 (see instructions) 102 Capital outlier reconciliation adjustment amount (see instructions) 103 Capital outlier reconciliation adjustment amount (see instructions) 104 Cad use of money for operating expenses (see instructions) 105 The rate used to calculate the time value of money (see instructions) 103 Time value of money for capital related expenses (see instructions) 104 OHSP bonus amount (see instructions) 105 Wilse Adjustment factor (see instructions) 106 HKR adjustment factor (see instructions) 107 HWBP adjustment factor (see instructions) 108 Wilse Adjustment factor (see instructions) 109 Wilse adjustment amount for HSP bonus payment (see instructions) 100 HKBP adjustment factor (see instructions) 100 HKBP adjustment factor (see instructions) 100 HKBP adjustment factor (see instructions) 1010 HKBP adjustment factor (see inst			
 1.98 Low Volume Payment-3 1.90 HAC adj ustment amount (see instructions) 1.00 Anount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 1.01 Sequestration adj ustment (see instructions) 1.02 Demonstration adj ustment adj ustment amount after sequestration 1.03 Sequestration adj ustment PARHM pass-throughs 1.01 Interim payments-PARHM 1.01 Tentative settlement/PARHM (for contractor use only) 1.02 Tentative settlement/PARHM (for contractor use only) 1.03 Eacace due provider/program -PARHM (see instructions) 1.04 Deptots 1.5-2. Chapter 1, 5115.2 1.05 EE COMPLETED BY CONTRACTOR (lines 90 through 96) 1.00 Operating outiler reconciliation adj ustment amount (see instructions) 1.00 Ten rate used to calculate the time value of money (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 HRP Adj ustment for HSP Bonus Payment 1.00 HRP Adj ustment for HSP Bonus Payment (see instructions) 1.00 HRR Adj ustment for HSP Bonus Payment (see instructions) 1.00 HRR Adj ustment for HSP Bonus Payment (see instructions) 1.00 HRR Adj ustment for HSP Bonus Payment (see instructions) 1.00 HRR Adj ustment for HSP Bonus Payment (see instructions)<td>0</td><td>0</td><td>70.</td>	0	0	70.
199 HAC adjustment amount (see instructions) 00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 % 70) 101 Sequestration adjustment (see instructions) 102 Demonstration payment adjustment amount after sequestration 103 Sequestration adjustment ARHM pass-throughs 101 Interim payments 101 Interim payments 101 Tentative settlement (for contractor use only) 101 Tentative settlement-PARHM (for contractor use only) 101 Balance due provider/program-PARHM (see instructions) 101 Belance due provider/program-PARHM (see instructions) 101 Belance due provider/program-PARHM (see instructions) 101 De EcoMPLETED BY CONTRACTOR (lines 90 through 96) 102 Operating outlier reconciliation adjustment amount (see instructions) 102 Gerulier from Wkst. E. Pt. A. line 2. 103 Degutal outlier reconciliation adjustment amount (see instructions) 104 Definition of moutlier reconciliation adjustment amount (see instructions) 105 Capital outlier of moup for operating expenses (see instructions) 104 Definition of Properating expenses (see instructions) 105 Definition of			70
 1.00 Amount² due provider (l'ine 67 minus lines 68 plus/minus lines 69 & 70) 1.01 Sequestration adjustment tese instructions) Demonstration payment adjustment amount after sequestration 1.03 Sequestration adjustment-PARHM pass-throughs 1.01 Interim payments-PARHM 1.01 Interim payments-PARHM (for contractor use only) 1.01 Tentative settlement-PARHM (see instructions) 1.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2. chapter 1, \$15.2 1.00 Derating outiler reconciliation adjustment amount (see instructions) 1.00 Operating outiler reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the time value of money (see instructions) 1.00 Time value of money for operating expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 HSP bonus amount (see instructions) 1.00 HSP bonus apyment Amount 1.00 HSP bolus amount (see instructions) 1.00 HSP adjustment factor (see instructions) 1.00 HSP adjustment for HSP Bonus payment (see instructions) 1.00 HRR Adjustment for HSP Bonus Payment 1.00 HRR Adjustment for HSP Bonus Payment 1.00 HRR Adjustment for HSP bonus payment (see instructions) 1.00 HRR Adjustment for HSP bonus payment (see instructions) 1.00 HRR Adjustment for HSP bonus payment (see instructions) 1.00 HRR Adjustment for HSP bonus payment (see instructions) 1.00 HRR Adjustment for HSP bonus payment (see instructions) 1.00 HRR adjustment factor		0	
101 Sequestration adjustment (see instructions) 102 Demonstration payment adjustment amount after sequestration 103 Sequestration adjustment-RARMM pass-throughs 101 Interim payments 101 Interim payments-PARMM (for contractor use only) 101 Tentative settlement (for contractor use only) 101 Balance due provider/program-PARMM (see instructions) 101 Balance due provider/program-PARMM (see instructions) 102 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3115.2 103 Capital outlier from Wkst. L, Pt. 1, line 2, or sum of 2.03 pl us 2.04 (see instructions) 104 Operating outlier reconciliation adjustment amount (see instructions) 105 Capital outlier reconciliation adjustment amount (see instructions) 106 Operating outlier reconciliation adjustment amount (see instructions) 107 The value of money for capital related expenses (see instructions) 108 Mustement for HSP Bonus Payment 109 HSP Bonus amount (see instructions) 100 HBP Adjustment factor (see instructions) 100 HSP Bonus amount for HSP Bonus payment (see instructions) 100 HSP Adjustment factor (see instructi		665, 142	
02 Demionstration payment adjustment amount after sequestration 03 Sequestration adjustment-PARHM pass-throughs 04 Interim payments 05 Interim payments 06 Interim payments 07 Tentative settlement-PARHM (for contractor use only) 07 Tentative settlement-PARHM (for contractor use only) 08 Balance due provider/program.PARHM (see instructions) 08 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 07 DE ECOMPLETE DB VCONTRACTOR (lines 90 through 96) 00 Operating outlier amount from Wsst. E, Pt. A, line 2, or sum of 2.03 08 Interving outlier reconciliation adjustment amount (see instructions) 00 Operating outlier reconciliation adjustment amount (see instructions) 00 The rate used to calculate the time value of money (see instructions) 00 Time value of money for capital related expenses (see instructions) 00 Bigs amount (see instructions) 10.00 HSP Bonus Payment Amount 11.00 HSP Bonus Payment for HSP Bonus Payment 10.00 HSP bonus amount for HSP bonus payment (see instructions) 10.00 HSP Bonus Payment factor (005, 142	1
 103 Sequestration adjustment-PARHM pass-throughs 201 Interim payments 201 Tentative settlement (for contractor use only) 201 Tentative settlement-PARHM (for contractor use only) 201 Tentative settlement-PARHM (for contractor use only) 201 Tentative settlement-PARHM (see instructions) 201 Balance due provider/program-PARHM (see instructions) 201 Portested amounts (nonal lowable cost report items) in accordance with OMS Pub. 15-2, chapter 1, \$115.2 200 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 202 Capital outlier reconciliation adjustment amount (see instructions) 203 Operating outlier reconciliation adjustment amount (see instructions) 204 Operating outlier reconciliation adjustment amount (see instructions) 205 Operating outlier reconciliation adjustment amount (see instructions) 206 The value of money for operating expenses (see instructions) 200 Time value of money for capital related expenses (see instructions) 200 Time value of money for Apparting expenses (see instructions) 200 HSP bonus amount (see instructions) 200 HKB Adjustment factor (see instructions) 200 HKB Adjustment f		0	
2.00 Interim payments 2.01 Interim payments-PARHM 3.01 Interim payments-PARHM (for contractor use only) 3.01 Tentative settlement-PARHM (for contractor use only) 3.01 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73) 3.01 Balance due provider/program-PARHM (see instructions) 5.00 Protested amounts (nonallowable cost report items) in accordance with OMS Pub 15-2, chapter 1, 515.2 10 BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0.00 Operating outlier reconciliation adjustment amount (see instructions) 1.00 Capital outlier reconciliation adjustment amount (see instructions) 1.00 The rea used to calculate the time value of money (see instructions) 1.00 The real used to calculate the time value of money (see instructions) 1.00 The value of money for operating expenses (see instructions) 1.00 HSP Bonus Payment Amount MVBP Adjustment for HSP Bonus Payment See instructions) 1.00 HVBP adjustment factor (see instructions) <t< td=""><td></td><td></td><td>71.</td></t<>			71.
 1. Interim payments-PARHM 2.00 Tentative settlement (for contractor use only) 1. Tentative settlement-PARHM (for contractor use only) 1. Tentative settlement (for mometation and use the payment amount (see instructions) 1. Tentative settlement (see instructions) 1. The value of money for operating expenses (see instructions) 1. The value of money for capital related expenses (see instructions) 1. The value of money for capital related expenses (see instructions) 1. The VA dy ustment factor (see instructions) 2. The VA dy ustment factor (see instructions) 2. The VA dy ustment factor (see inst		509, 361	
 1.00 Tentative settlement (for contractor use only) 1.01 Tentative settlement-PARHM (for contractor use only) 1.01 Tentative settlement-PARHM (for contractor use only) 1.02 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73) 1.03 Balance due provider/program-PARHM (see instructions) 1.04 Fortested amounts (nonallowable cost report items) in accordance with OMS Pub 15-2, chapter 1, §115.2 1.05 BE COMPLETED BY CONTRACTOR (lines 90 through 96) 1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 1.00 Capital outlier reconciliation adjustment amount (see instructions) 1.00 Capital outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the time value of money (see instructions) 1.00 Time value of money for opariting expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 HSP bonus amount (see instructions) 1.00 HMSP adjustment for HSP Bonus Payment (see instructions) 1.00 HMSP adjustment for HSP Bonus Payment (see instructions) 1.00 HMSP adjustment for HSP Bonus Payment (see instructions) 1.00 HMSP adjustment for HSP bonus payment (see instructions) 1.00 HMSP adjustment for HSP bonus payment (see instructions) 1.00 HMSP adjustment for HSP bonus payment (see instructions) 1.00 HMSP adjustment factor (see instructions) 2.00 HMSP adjustment for HSP bonus payment (see instructions) 2.00 HMSP adjustment for HSP bonus payment (see instructions) 2.00 HMSP adjustment for HSP bonus payment (see instructions) 3.00 Case-mix adju			72.
 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with (MS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) Capital outlier reconciliation adjustment amount (see instructions) The value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) The value of money for capital related expenses (see instructions) The value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HVBP Adjustment for HSP Bonus Payment HVBP Adjustment factor (see instructions) HRR Adjustment factor (see instructions) HRR Adjustment for HSP Bonus payment (see instructions) Rural Communit y Hospital Demonstration Project (\$410A Demonstration) Adjustment Ob Its this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Relmbursement Ob Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49) Medicare discharges (see instructions) Modicare discharges (see instructions) Modicare discharges (see instructions) Medicare discharges (see instructions) Medicare discharges (see instructions) Modicare discharges (see instructions) Modicare discharges (see instructions) Modicare discharges (see instructions) Modicare discharges (see instructions		0	73.
73) 1.01 Balance due provider/program-PARHM (see instructions) 1.01 Balance due provider/program-PARHM (see instructions) 1.01 Balance due provider/program-PARHM (see instructions) 1.01 CMS Pub. 15-2, chapter 1, \$115.2 1.01 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 1.01 Jus 2.04 (see instructions) 1.01 Coptating outlier reconciliation adjustment amount (see instructions) 0.00 Operating outlier reconciliation adjustment amount (see instructions) 1.01 D0 Operating outlier reconciliation adjustment amount (see instructions) 1.02 D1 Operating outlier reconciliation adjustment amount (see instructions) 1.02 D1 Operating outlier reconciliation adjustment amount (see instructions) 1.00 D1 Operating amount (see instructions) 1.00 D1 Operating dujustment for HSP Bonus Payment 1.01 D1 Operating dujustment factor (see instructions) 1.02 D1 Operating dujustment factor (see instructions) 1.01 D1 Operating dujustment factor (see instructions) 1.02 D1 Operating dujustment factor (see instructions) 1.03 <			73.
 1.01 Bajance due provider/program-PARHM (see instructions) Protested amounts (nonal lowable cost report items) in accordance with (DKS Pub. 15-2, Chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 1.00 Capital outlier reconciliation adjustment amount (see instructions) 0.00 The rate used to calculate the time value of money (see instructions) 0.01 Time value of money for operating expenses (see instructions) 0.02 Time value of money for capital related expenses (see instructions) 0.01 HSP Bonus Payment Amount 1.00 HSP Bonus Payment factor (see instructions) 1.00 HKR adjustment for HSP Bonus Payment 1.00 HKR adjustment factor (see instructions) 2.00 HKR adjustment factor (see instructions) 2.00 HKR adjustment factor (see instructions) 2.01 HKR adjustment factor (see instructions) 2.02 HKR adjustment factor (see instructions) 2.03 Undicare discharges (see instructions) 2.04 HKR adjustment factor (see instructions) 2.05 HKR adjustment factor (see instructions) 2.06 Value and the service costs (from Wkst. D-1, Pt. 11, line 49) 2.00 Medicare discharges (see instructions) 2.00 Kadicare discharges (see instructions)<		155, 781	74.
 5.00 Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 1.00 Capital outlier reconciliation adjustment amount (see instructions) 0.0 Capital outlier reconciliation adjustment amount (see instructions) 0.0 The rate used to calculate the time value of money (see instructions) 5.00 Time value of money for operating expenses (see instructions) 5.00 Time value of money for capital related expenses (see instructions) 5.00 HWP Adjustment for HSP Bonus Payment HSP Bonus Payment Amount 0.100 HWP Adjustment for HSP Bonus Payment 0.100 HWP Adjustment for HSP Bonus Payment 0.100 HWP Adjustment for HSP Bonus Payment 0.100 HWP Adjustment for HSP Bonus Payment (see instructions) 0.100 HRR adjustment for HSP conus payment (see instructions) 0.1100 Her adjustment factor (see instructions) 0.1100 Her adjustment factor (see instructions) 0.1100 Her adjustment factor (see instructions) 0.1100 Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49) 0.200 Medicare diget amount 0.200 Eare target amount 0.200 Eare target amount 200 Medicare target amount 200 Medicare target amount 201 Demonstration Target Amount Limitation (N/A in first year of the curren period) 202 Medicare target amount 203 Medicare target amount 204 Her Adjustment target Amount Limitation (see instructions) 204 Medicare target amount 205 Medicare target amount (line 203 times line 204) 200 Medicare target amount (line 203 times line 204) 200 Medicare target amount (mole the \$410A Demonstration (see instructions) 200 Medicare target amount (line 203 times line			
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96) 0.00 Operating outilier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 1.00 Capital outlier from Wkst. L, Pt. I, line 2 2.00 Operating outlier reconciliation adjustment amount (see instructions) 3.00 Capital outlier reconciliation adjustment amount (see instructions) 3.00 The rate used to calculate the time value of money (see instructions) 5.00 Time value of money for operating expenses (see instructions) 5.00 Time value of money for capital related expenses (see instructions) 5.00 Time value of money for capital related expenses (see instructions) 6.00 HSP bonus amount (see instructions) HSP Bonus Payment Amount 10.00 HVBP adjustment for HSP Bonus Payment 10.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 8.00 This the first year of the current 5-year demonstration Adjustment 3.00 Cast Ra djustment factor (see instructions) 8.00 Case-mix adjustment factor (see instructions) 9.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adj			74.
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96) 0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 1.00 Capital outlier from Wkst. L, Pt. I, line 2 0.00 perating outlier reconciliation adjustment amount (see instructions) 1.00 Capital outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the time value of money (see instructions) 1.00 The value of money for capital related expenses (see instructions) 1.00 Time value of money for capital related expenses (see instructions) 1.00 The value of money for capital related expenses (see instructions) 1.00 The value of money for capital related expenses (see instructions) 1.00 HSP bonus amount (see instructions) 1.00 HVBP adjustment for HSP Bonus Payment (see instructions) 1.00 HVBP adjustment for HSP Bonus payment (see instructions) 1.00 HVBP adjustment factor (see instructions) 1.00 HVBP adjustment factor (see instructions) 1.00 HVBP adjustment factor (see instructions) 1.00 HRR adjustment factor (see instructions) 1.00 Medicare inpatient amount for HSP bonus payment (see instructions) 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 1.00 Medicare discharges (see instructions) 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 1.00 Medicare inpatient factor (see instructions) 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 1.00 Medicare target amount 1.00 Medicare target amount (line 203 times line 204) 1.00 Medicare target amount 1 1.00 Medicare target amount 1 1.00 Medicare target amount (line 203 times line 205) 1.00 Medicare target amount (line 203 times line 205) 1.00 Medicare target amount the 5410A Demonstration (see instructions) 1.00 Medicare target amount (line 203 times line 205) 1.00 Medicare target amount tome the \$410A Demonstration (see instructions) 1.00 Medicare target amount tome the \$410A Demonstration (see instructions) 1.00 Medicare PS payment (see instru		31, 262	75.
 0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 0.02 Capital outlier from Wkst. L, Pt. I, line 2 0.09 operating outlier reconciliation adjustment amount (see instructions) 0.00 Capital outlier reconciliation adjustment amount (see instructions) 0.01 The rate used to calculate the time value of money (see instructions) 0.02 Time value of money for operating expenses (see instructions) 0.03 Time value of money for capital related expenses (see instructions) 0.04 Time value of money for capital related expenses (see instructions) 0.05 Time value of money for capital related expenses (see instructions) 0.06 HSP bonus amount (see instructions) 0.07 HVBP adjustment factor (see instructions) 0.08 HVBP adjustment for HSP Bonus Payment 0.09 HVBP adjustment for HSP bonus payment (see instructions) 0.00 HRR adjustment factor (see instructions) 0.01 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49) 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49) 0.00 Medicare inpatient routine cost cap (line 202 times line 205) 0.01 Keine adjusted target amount (line 203 times line 205) 0.02 Adjustment to Medicare Part A Inpatient Reimbursement 0.00 Program reimbursement under the \$410A Demonstration (see instructions) 0.00 Reserved for future use 0.00 Total ad			
 plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, Line 2 Operating outlier reconciliation adjustment amount (see instructions) Capital outlier reconciliation adjustment amount (see instructions) The rate used to calculate the time value of money (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP Bonus mount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP Adjustment for HSP Bonus Payment No HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment No HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment Cost Reimbursement No Gase-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) O Medicare inpatient service costs (from Wkst. D-1, Pt. 11, Line 49) O Medicare target amount Case-mix adjusted target amount (line 203 times Line 204) O Medicare target amount O Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions) Adjustment to Medicare IPPS payments (see instructions) O Medicare Part A Inpatient service costs (from Wkst. E, Pt. A, Line 59) O Medicare Inpatient service costs (from Wkst. E, Pt. A, Line 59) O Medicare Part A Inpatient Reimbursement O Reserved for future use O Reserved for future use O Reserved for future use O Medicare IPPS payments (see instructions) 		0	90
 Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see instructions) Capital outlier reconciliation adjustment amount (see instructions) The rate used to calculate the time value of money (see instructions) Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount Oo HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP Adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment Adjustment for HSP Bonus Payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Oo Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Oo Gase-mix adjustment factor (see instructions) Oo Gase-mix adjustment factor (see instructions) Oo Medicare target amount O Bedicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49) Oo Gase-mix adjusted target amount (line 203 times line 204) Oo Medicare target amount Of Program reimbursement under the §410A Demonstration (see instructions) Adjustment to Medicare IPPS payments (see instructions) Operating of the service costs (from Wkst. E, Pt. A, line 59) Oo Adjustment to Medicare IPPS payments (see instructions) Oo Reserved for future use Oo Total adjustment to Medicare IPPS payments (see instructions) 			90
 Operating outlier reconciliation adjustment amount (see instructions) Capital outlier reconciliation adjustment amount (see instructions) The rate used to calculate the time value of money (see instructions) Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount Ob HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment (see instructions) HR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment for HSP Bonus Payment (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment Ob HSP adjustment factor (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Ob Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Ob decare discharges (see instructions) Capitation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount (line 203 times line 204) Ob Medicare are part A inpatient Reimbursement Op Program reimbursement under the \$410A Demonstration (see instructions) Adjustment to Medicare IPPS payments (see instructions) Op Reserved for future use Op Adjustment to Medicare IPPS payments (see instructions) 		0	91
Capital outlier reconciliation adjustment amount (see instructions) O The rate used to calculate the time value of money (see instructions) O Time value of money for operating expenses (see instructions) O Time value of money for capital related expenses (see instructions) O Time value of money for capital related expenses (see instructions) O Time value of money for capital related expenses (see instructions) O HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) HRR Adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0.01 Its is the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 1.00 Medicare discharges (see instructions) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment f		Ö	
100 The rate used to calculate the time value of money (see instructions) 100 Time value of money for operating expenses (see instructions) 101 Time value of money for capital related expenses (see instructions) 102 Time value of money for capital related expenses (see instructions) 103 Time value of money for capital related expenses (see instructions) 100 HSP Bonus Payment Amount 100 HSP bonus amount (see instructions) 100 HVBP adjustment for HSP Bonus Payment 100 HVBP adjustment for HSP Bonus Payment (see instructions) 101 HVBR Adjustment for HSP Bonus Payment 300 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare target amount 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjusted target amount (line 203 times line 204)		0	
.00 Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount .00 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment .00 1.00 HSP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVR adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 8.00 HRR adjustment factor (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment 0.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medi care discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount (line 203 times line 204) 6.00 Medica		0.00	
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment for HSP Bonus Payment 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) <td></td> <td>0</td> <td>95</td>		0	95
 10.00 HSP bonus amount (see instructions) HVBP Adj ustment for HSP Bonus Payment 11.00 HVBP adj ustment factor (see instructions) 20.00 HVBP adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adj ustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Cost Reimbursement Medi care inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medi care inpatient factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) Medi care target amount Case-mix adj usted target amount (line 203 times line 204) Medi care inpatient routine cost cap (line 202 times line 205) Adj ustment to Medi care Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medi care Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Medi adj ustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 		0	96.
 0.00 HSP bonus amount (see instructions) HVBP Adj ustment for HSP Bonus Payment 11.00 HVBP adj ustment factor (see instructions) 200 HVBP adj ustment factor (see instructions) 200 HVBP adj ustment factor (see instructions) HRR adj ustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adj ustment 000 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 10.00 Medi care inpatient service costs (from Wkst. D-1, Pt. II, line 49) 200 Medi care inpatient factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medi care target amount 5.00 Case-mix adj usted target amount (line 203 times line 204) 6.00 Medi care inpatient routine cost cap (line 202 times line 205) Adj ustment to Medi care Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medi care Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adj ustment to Medi care IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 	Prior to 10/1 1.00	0n/After 10/1 2.00	-
HVBP Adj ustment for HSP Bonus Payment 1.00 HVBP adj ustment factor (see instructions) 22.00 HVBP adj ustment factor (see instructions) HRR Adj ustment for HSP Bonus Payment (see instructions) HRR adj ustment factor (see instructions) 4.00 HRR adj ustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adj ustment 00.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Cost Reimbursement 11.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 22.00 Medicare target amount 23.00 Case-mix adj ustment factor (see instructions) 23.00 Case-mix adj ustment factor (see instructions) 24.00 Medicare target amount 25.00 Case-mix adj ustment routine cost cap (line 203 times line 204) 26.00 Medicare inpatient routine cost cap (line 202 times line 205) 27.00 Program reimbursement under the §410A Demonstration (see instructions) 28.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 29.00 Adj ustment to Medicare IPPS payments (see instructions) 20.00			
 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 00.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjustment factor (see instructions) 06.00 Medicare target amount 07.00 Program reimbursement under the §410A Demonstration (see instructions) 08.00 Medicare Part A Inpatient Reimbursement 09.00 Adjustment to Medicare IPPS payments (see instructions) 00 Medicare for future use 01.00 Program reimbursement under the S410A Demonstration (see instructions) 03.00 Case-nix adjustment to Medicare IPPS payments (see instructions) 	0	0	100.
 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjustment routine cost cap (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 		1	
HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0.00 Is the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instruc	0.000000000		
 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0. 00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9. 00 Adjustment to Medicare IPPS payments (see instructions) 0. 00 Total adjustment to Medicare IPPS payments (see instructions) 0. 00 Total adjustment to Medicare IPPS payments (see instructions) 	0	0	102
 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 0.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Total adjustment to Medicare IPPS payments (see instructions) 	0.0000	0.0000	1400
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment D. 00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare IPPS payments (see instructions) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) 0.00 Comparision of PPS versus Cost Reimbursement	0.0000		
 0.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 0.00 Medicare discharges (see instructions) 0.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 0.00 Medicare target amount 0.00 Medicare target amount 0.00 Medicare inpatient routine cost cap (line 203 times line 204) 0.00 Medicare part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 0.00 Medicare IPPS payments (see instructions) 0.00 Reserved for future use 0.01 Total adjustment to Medicare IPPS payments (see instructions) 0.02 Comparision of PPS versus Cost Reimbursement 	0	0	104
Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement		I	200
Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare IPPS payments (see instructions) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			200
 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) 		1	
 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			201
 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 5. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9. 00 Adjustment to Medicare IPPS payments (see instructions) 1. 00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			202
 period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 5. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9. 00 Adjustment to Medicare IPPS payments (see instructions) 1. 00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			203
 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9. 00 Adjustment to Medicare IPPS payments (see instructions) 9. 00 Reserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions) 	nt 5-year demonst	tration	
 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			100.
 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9. 00 Adjustment to Medicare IPPS payments (see instructions) 0. 00 Reserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			204
Adjustment to Medicare Part A Inpatient Reimbursement7.00Program reimbursement under the §410A Demonstration (see instructions)8.00Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)9.00Adjustment to Medicare IPPS payments (see instructions)0.00Reserved for future use1.00Total adjustment to Medicare IPPS payments (see instructions)0.00Comparision of PPS versus Cost Reimbursement			205
 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 9. 00 Adjustment to Medicare IPPS payments (see instructions) 0. 00 Reserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 		I	206
 B. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) D. 00 Adjustment to Medicare IPPS payments (see instructions) D. 00 Reserved for future use I. 00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			207
 P. 00 Adjustment to Medicare IPPS payments (see instructions) D. 00 Reserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 			208
0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			209
1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			210
Comparision of PPS versus Cost Reimbursement			211
	L		1
2. VOLIVIAL AUJUSTINENT TO MEDICALE FALL A TEES PAYINENTS (TEUN TIME 211)			212
3.00 Low-volume adjustment (see instructions)			213
8.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218

	Financial Systems FAIRBAN ATLON OF RELMBURSEMENT SETTLEMENT	KS Provider CCN: 15-0179	In Lie Period:	u of Form CMS-: Worksheet E	2552-10
			From 07/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	1
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		0 24, 914	
2.00	OPPS payments			24, 914 25, 465	1
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COL. 13, TINE 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	•
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.130	(e)			
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	17.00
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds l	ine 11) (see	0	
20.00	instructions)	- 			00.00
20. 00	Excess of reasonable cost over customary charges (complete or instructions)	niy if line ii exceeds i	The 18) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			25, 465	•
05 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	`			1 05 00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	ructions)	0 5, 112	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•	,	20, 353	
20.00	instructions)	line EO)			28.00
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)	-		0	
30.00	Subtotal (sum of lines 27 through 29)	, ,		20, 353	•
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			0	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		20, 353	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
	Subtotal (see instructions)			20, 353	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration	· · · · · · · · ·		0	
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctions)	0	
40.00	Subtotal (see instructions)			20, 353	
40. 01	Sequestration adjustment (see instructions)			0	40.01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
40.03	Interim payments			20, 353	
41.01	Interim payments-PARHM				41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00
42.01	Balance due provider/program (see instructions)			0	•
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR			I	1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
	Time Value of Money (see instructions)			0.00	•
	Total (sum of lines 91 and 93)			0	•

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-0179	Period: From 07/01/2020 To 12/31/2020		pared
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider	1.00	509, 36		20, 353	1.
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,			0	0	2.
00	write "NONE" or enter a zero 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.
	Program to Provider				1	
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3
)4				0	0	3
)5	Durau i daura das Durauman			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
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)		509, 36	51	20, 353	4
	TO BE COMPLETED BY CONTRACTOR					[
0	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program	1			-	
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		155, 78		0	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		665, 14		20,353 NPR Date	7
		C		Contractor Number 1.00	MPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor	L L		1.00	2.00	8

Heal th	Financial Systems FAIRB	ANKS	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020		epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				4
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase or line 168	f certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions))			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	d line 31) (see instructior	is)		32.00

	Financial Systems	FAI RBANKS		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Pre 8/2/2021 3:31	pared:
		Title XIX	Hospi tal	Cost	pm
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER	HEALTH SERVICES FOR TITLES V OR X	IX SERVICES		-
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		227.004		1 1 00
1.00 2.00	Inpatient hospital/SNF/NF services Medical and other services		327, 884	189	1.00 2.00
3.00	Organ acquisition (certified transplant centers only	()	0	107	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1)	327, 884	189	
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		327, 884	189	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
0.00	Reasonabl e Charges				0.00
8.00 9.00	Routine service charges Ancillary service charges		0	687	8.00 9.00
9.00 10.00	Organ acquisition charges, net of revenue		0	007	10.00
11.00	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11))	0	687	
	CUSTOMARY CHARGES	·	-		
13.00	Amount actually collected from patients liable for p	payment for services on a charge	0	0	13.00
4.4.00	basi s			0	11.00
14.00	Amounts that would have been realized from patients a charge basis had such payment been made in accorda		n 0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.00000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0.000000	687	1
17.00	Excess of customary charges over reasonable cost (co	omplete only if line 16 exceeds	0	498	
	line 4) (see instructions)	1 5			
18.00	Excess of reasonable cost over customary charges (co	omplete only if line 4 exceeds lin	e 327, 884	0	18.00
	16) (see instructions)				10.00
19.00	Interns and Residents (see instructions)	(and instructions)	0	0	
	Cost of physicians' services in a teaching hospital Cost of covered services (enter the lesser of line 4		0	0 189	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 mus	•		107	21.00
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through cos	sts	0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00 29.00	Customary charges (title V or XIX PPS covered servic	ces on y)	0	0 189	
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	109	29.00
30.00	Excess of reasonable cost (from line 18)		327, 884	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus line	es 5 and 6)	0277007	189	
32.00	Deducti bl es	· · · · · · · · · · · · · · · · · · ·	0	0	1
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of li	nes 32 and 33)	0	189	
37.00 38.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0	0 189	
38.00	Direct graduate medical education payments (from Wks	st F-4)	0	189	38.00
40.00	Total amount payable to the provider (sum of lines 3		0	189	
41.00	Interim payments		0	0	1
42.00	Balance due provider/program (line 40 minus line 41))	0	189	
				0	
43.00	Protested amounts (nonallowable cost report items) i chapter 1, §115.2	IT ACCOLUANCE WITH CMS FUD 15-2,	9	0	10.00

	Financial Systems FAIRBA SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider C	F	Period: From 07/01/2020 To 12/31/2020	u of Form CMS-: Worksheet G Date/Time Pre	
ii y)		General Fund	Speci fi c	Endowment Fund	8/2/2021 3:31 Plant Fund	pm
		1.00	Purpose Fund 2.00	3.00	4.00	
-	CURRENT ASSETS		-	-1 -1		
	Cash on hand in banks	1, 916, 495		-	0	1.0
	Temporary investments Notes receivable	0		-	0	2.
	Accounts receivable	8, 894, 214			0	
	Other receivable	-6, 579, 474			0	
	Allowances for uncollectible notes and accounts receivable	354, 898	· · · · ·	, i	0	6.
	Inventory	14, 014		0	0	7.
00	Prepai d'expenses	24, 605	0	0 0	0	8.
00	Other current assets	62, 029	(0 0	0	9.
0.00	Due from other funds	0	(-	0	10.
	Total current assets (sum of lines 1-10)	4, 686, 781	(00	0	11.
	I XED ASSETS	450.000				1
	Land	150, 000	(0	12.
	Land improvements Accumulated depreciation	0			0	13.
	Buildings	15, 426, 077		, i	0	14.
	Accumul ated depreciation	n 13, 420, 077			0	16.
	Leasehold improvements	382, 577			0	17.
	Accumul ated depreciation	0		0	0	18.
	Fixed equipment	794, 862	0	0	0	19.
. 00	Accumul ated depreciation	0	(0 0	0	20.
	Automobiles and trucks	58, 723		0 0	0	21.
	Accumulated depreciation	0	0	-	0	22.
	Major movable equipment	0	(0 0	0	23.
	Accumulated depreciation	-727, 016		0	0	24.
	Minor equipment depreciable	0			0	25
	Accumulated depreciation HIT designated Assets	0			0	26.
	Accumul ated depreciation				0	28.
	Mi nor equi pment-nondepreci abl e	60, 000		0	0	29.
	Total fixed assets (sum of lines 12-29)	16, 145, 223			0	30.
	OTHER ASSETS			· · · · · · · · · · · · · · · · · · ·		
. 00 🛛	Investments	0	(0 0	0	31.
. 00	Deposits on Leases	0	(0 0	0	32.
	Due from owners/officers	0	0	0 0	0	33.
	Other assets	-6, 992, 796		-	0	34.
	Total other assets (sum of lines 31-34)	-6, 992, 796			0	35.
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	13, 839, 208		0 0	0	36.
	Accounts payable	279, 164	0	0	0	37.
	Salaries, wages, and fees payable	0			0	38.
	Payroll taxes payable	0	C	0	0	
. 00	Notes and Loans payable (short term)	0	(0 0	0	40
	Deferred income	0	0	0 0	0	41
	Accelerated payments	0				42.
1	Due to other funds	0	0	-	0	
	Other current liabilities	100, 489			0	
	Total current liabilities (sum of lines 37 thru 44)	379, 653	(0 0	0	45.
-	LONG TERM LIABILITIES			0 0	0	46.
	Mortgage payable Notes payable				0	46.
	Unsecured Loans	n 0			0	
	Other long term liabilities	13, 713			0	
	Total long term liabilities (sum of lines 46 thru 49)	13, 713		0	0	
00	Total liabilities (sum of lines 45 and 50)	393, 366	(0 0	0	51
C	CAPI TAL ACCOUNTS					
00	General fund balance	13, 445, 842				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	_	56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
	Total fund balances (sum of lines 52 thru 58)	13, 445, 842	(0	59
	Total liabilities and fund balances (sum of lines 51 and	13, 839, 208	-		0	60
					0	

Health Financial Systems		FAI RBANKS		In Lieu of Form CMS-2552-10			
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet G-1 Date/Time Pre 8/2/2021 3:31	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 17,681,974	3.00	4.00	5.00	1.00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\end{array}$	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	2 0 0 0 0 0 0 0	-4, 236, 134 13, 445, 840 2 13, 445, 842			0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance <u>sheet (line 11 minus line 18)</u>	Endowment Fund	0 13, 445, 842 Pl ant	Fund	0 0 0 0	0	16. 00 17. 00 18. 00 19. 00
				T unu			
1 00		6.00	7.00	8.00			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems FAIRBANK	<s< th=""><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></s<>		In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0179	Period: From 07/01/2020 To 12/31/2020	Worksheet G-2 Parts I & II Date/Time Pre 8/2/2021 3:31	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					
1.00	Hospi tal	1	11, 285, 91	3	11, 285, 913	1.00
2.00	SUBPROVIDER - IPF		11, 200, 71	5	11, 200, 710	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					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				44 005 040	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		11, 285, 91	3	11, 285, 913	10.00
11.00	Intensive Care Type Inpatient Hospital Services					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT			0	0	13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T			0	Ű	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11, 285, 91		11, 285, 913	
18.00	Ancillary services			0 5, 404, 360	5, 404, 360	
19.00	Outpatient services			0 0	0	19.00
20.00 21.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	20.00 21.00
21.00	HOME HEALTH AGENCY			0 0	0	21.00
22.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	11, 285, 91	3 5, 404, 360	16, 690, 273	28.00
	G-3, line 1)					
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)	1		14, 555, 065		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 (SPECI FY)			0		37.00
38.00				0		38.00
39.00 40.00				0		39.00 40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			́ ∩		41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		14, 555, 065		43.00
. 51 60	to Wkst. G-3, Line 4)	, (1. 2.101 01		,,,		
						-

Heal th	Financial Systems	FAI RBANKS	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-	-0179 Period: From 07/01/2020 To 12/31/2020		pared:
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	column 3 line 28)	· · · · · · · · · · · · · · · · · · ·	16, 690, 273	1.00
2.00	Less contractual allowances and discounts on			6, 797, 964	
3.00	Net patient revenues (line 1 minus line 2)			9, 892, 309	
4.00	Less total operating expenses (from Wkst. G-2	Part II, line 43)		14, 555, 065	
5.00	Net income from service to patients (line 3 m			-4, 662, 756	
	OTHER I NCOME			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
6.00	Contributions, donations, bequests, etc			119, 129	6.00
7.00	Income from investments			3, 017	7.00
8.00	Revenues from telephone and other miscellaneo	us communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	
14.00	Revenue from meals sold to employees and gues	ts		43, 192	
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical sup			0	
17.00	Revenue from sale of drugs to other than pati-			0	
18.00	Revenue from sale of medical records and abst	racts		2, 933	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	tc.)		0	
20.00	Revenue from gifts, flowers, coffee shops, and	d canteen		23, 462	20.00
21.00	Rental of vending machines			1, 912	
22.00	Rental of hospital space			192, 745	
23.00	Governmental appropriations			0	23.00
24.00	MI SC REVENUE			40, 232	24.00
24.50	COVI D-19 PHE Fundi ng			0	24.50
25.00	Total other income (sum of lines 6-24)			426, 622	
26.00	Total (line 5 plus line 25)			-4, 236, 134	
27.00	INCOME TAX			0	
28.00	Total other expenses (sum of line 27 and subs			0	
29.00	Net income (or loss) for the period (line 26)	ninus line 28)		-4, 236, 134	29.00

		I RBANKS		u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0179	Period: From 07/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	рш
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			34, 666	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00				0	2.00
2.01					2. 01
3.00					3.00
4.00	Number of interns & residents (see instructions)				4.00
5.00					5.00
6.00	Indirect medical education adjustment (multiply line 5 1.01) (see instructions)	0	6.00		
7.00	Percentage of SSI recipient patient days to Medicare Pa	0.00	7.00		
	30) (see instructions)	0.00			
8.00					
9.00					9.00
10.00					10.00
	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)			34, 666	12.00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruction			0	1.00
2.00				0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 1	2)		0	3.00
4.00 5.00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4.00 5.00
5.00	Total Theatrent program capital cost (The 5_x The 4)			0	5.00
				1.00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1.00 2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circu	metanese (cas instructions)		0	1.00 2.00
3.00	Net program inpatient capital costs (line 1 minus line 3			0	2.00 3.00
4.00	Applicable exception percentage (see instructions)	2)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line -	4)		0.00	5.00
6.00	Percentage adjustment for extraordinary circumstances (0.00	6.00
7.00	Adjustment to capital minimum payment level for extraord		x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9.00	Current year capital payments (from Part I, line 12, as	appl i cabl e)		0	9.00
	Current year comparison of capital minimum payment level		less line 9)	0	10.00
10.00	Carryover of accumulated capital minimum payment level	over capital payment (from pr	ior year	0	11.00
11.00	Worksheet L, Part III, line 14)	tal navments (line 10 plus li	ne 11)		12 00
11.00 12.00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi			0	
 11. 00 12. 00 13. 00 	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive,	enter the amount on this lin	e)	0	13.00
 11. 00 12. 00 13. 00 	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level	enter the amount on this lin	e)	-	12.00 13.00 14.00
10.00 11.00 12.00 13.00 14.00 15.00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)	enter the amount on this lin over capital payment for the	e)	0	13.00
11. 00 12. 00 13. 00 14. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	enter the amount on this lin over capital payment for the ee instructions)	e)	0 0	13.00 14.00