This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/29/2021 2:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/29/2021 Time: 2:22 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH CRAWFORDSVILLE (15-0022) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-73,478	-33,967	0	0	1.00
2.00	Subprovider - IPF	0	2,390	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-71,088	-33,967	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 2:22 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1710 LAFAYETTE RD	PO Box:			1.00
2.00	City: CRAWFORDSVILLE	State: IN	Zip Code: 47933	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANCISCAN HEALTH CRAWFORDSVILLE	150022	99915	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	FRANCISCAN HEALTH CRAWFORDSVILLE PSY	15S022	99915	4	01/01/1995	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	73	0	0	0	206	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2020	12/31/2020	38.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/29/2021 2:22 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	291,933	0	182,000	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/29/2021 2:22 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/20/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/29/2021 2:22 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE		HOWELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927		STEVEN.HOWELL@FRANCISCANALLIANCE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/29/2021 2:22 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER COST REPORTING		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,784	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		24	8,784	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,830	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		29	10,614	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	11	3,410		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,442	203	2,801			1.00
2.00	HMO and other (see instructions)	875	0				2.00
3.00	HMO IPF Subprovider	375	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,442	203	2,801			7.00
8.00	INTENSIVE CARE UNIT	163	56	480			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,605	259	3,281	0.00	227.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	863	32	1,315	0.00	12.08	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	239.28	27.00
28.00	Observation Bed Days		177	1,165			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	519	72	912	1.00
2.00	HMO and other (see instructions)			216	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	519	72	912	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	36	1	118	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 7/29/2021 2:22 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,513,066	837,738	14,350,804	495,758.00	28.95	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,525,129	0	2,525,129	86,246.00	29.28	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,550,033	0	1,550,033	22,948.00	67.55	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		4,303,735	0	4,303,735	116,552.00	36.93	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,880,289	0	2,880,289			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		610,914	0	610,914			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,270,214	0	1,270,214			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 7/29/2021 2:22 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	134,670	66,065	200,735	8,595.00	23.35	26.00
27.00	Administrative & General	5.00	794,776	518,708	1,313,484	56,241.00	23.35	27.00
28.00	Administrative & General under contract (see inst.)		213,246	0	213,246	2,009.00	106.15	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	334,006	0	334,006	20,703.00	16.13	30.00
31.00	Laundry & Linen Service	8.00	12,565	0	12,565	780.00	16.11	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	358,388	-161,369	197,019	10,623.00	18.55	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	161,369	161,369	8,701.00	18.55	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	262,650	252,965	515,615	8,308.00	62.06	38.00
39.00	Central Services and Supply	14.00	61,288	0	61,288	2,241.00	27.35	39.00
40.00	Pharmacy	15.00	341,465	0	341,465	11,830.00	28.86	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 7/29/2021 2:22 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		13,726,312	837,738	14,564,050	497,767.00	29.26	1.00
2.00	Excluded area salaries (see instructions)		2,525,129	0	2,525,129	86,246.00	29.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,201,183	837,738	12,038,921	411,521.00	29.25	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,853,768	0	5,853,768	139,500.00	41.96	4.00
5.00	Subtotal wage-related costs (see inst.)		4,150,503	0	4,150,503	0.00	34.48	5.00
6.00	Total (sum of lines 3 thru 5)		21,205,454	837,738	22,043,192	551,021.00	40.00	6.00
7.00	Total overhead cost (see instructions)		2,513,054	837,738	3,350,792	130,031.00	25.77	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 7/29/2021 2:22 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	899,508	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,484,412	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	141,235	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	35,948	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	41,570	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	888,530	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,491,203	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V Date/Time Prepared: 7/29/2021 2:22 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,550,033	3,491,203	1.00
2.00	Hospital	1,550,033	3,491,203	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/29/2021 2:22 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.223503	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	522,514	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,085,432	6.00
7.00	Medicaid cost (line 1 times line 6)	689,603	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	167,089	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	167,089	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,086,240	4,710,041	10,796,281	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,360,293	4,710,041	6,070,334	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,360,293	4,710,041	6,070,334	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	529,648	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	155,257	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	238,857	27.01
28.00	Non-Medicare bad debt expense (see instructions)	290,791	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	148,593	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,218,927	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,386,016	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,275,685	4,275,685	1,199,838	5,475,523	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		16,147	16,147	43,067	59,214	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134,670	3,715,775	3,850,445	0	3,850,445	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	794,776	14,788,813	15,583,589	-1,267,464	14,316,125	5.00
7.00	00700	OPERATION OF PLANT	334,006	1,022,462	1,356,468	-6,952	1,349,516	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,565	128,844	141,409	-229	141,180	8.00
9.00	00900	HOUSEKEEPING	0	545,050	545,050	-3,988	541,062	9.00
10.00	01000	DIETARY	358,388	194,769	553,157	-250,823	302,334	10.00
11.00	01100	CAFETERIA	0	0	0	247,628	247,628	11.00
13.00	01300	NURSING ADMINISTRATION	262,650	198,730	461,380	0	461,380	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,288	211,351	272,639	-57,137	215,502	14.00
15.00	01500	PHARMACY	341,465	1,174,104	1,515,569	-1,098,105	417,464	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,319,076	497,505	1,816,581	-64,039	1,752,542	30.00
31.00	03100	INTENSIVE CARE UNIT	684,098	156,560	840,658	-26,277	814,381	31.00
40.00	04000	SUBPROVIDER - IPF	1,064,559	78,678	1,143,237	-10,020	1,133,217	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,375,339	2,429,108	3,804,447	-1,789,061	2,015,386	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,114,779	289,992	1,404,771	-127,461	1,277,310	54.00
54.01	05401	ULTRASOUND	75,739	139,653	215,392	0	215,392	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	529,762	8,941,937	9,471,699	-8,263,686	1,208,013	55.00
56.00	05600	RADIOISOTOPE	82,344	90,344	172,688	-90,318	82,370	56.00
60.00	06000	LABORATORY	0	2,770,080	2,770,080	-246	2,769,834	60.00
65.00	06500	RESPIRATORY THERAPY	546,745	69,306	616,051	3,123	619,174	65.00
66.00	06600	PHYSICAL THERAPY	605,545	70,603	676,148	-9,327	666,821	66.00
69.00	06900	ELECTROCARDIOLOGY	386,732	43,478	430,210	-107,086	323,124	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,807,292	1,807,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	769,152	769,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,447,207	9,447,207	73.00
76.00	03020	ACUPUNCTURE	43,860	95	43,955	0	43,955	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	132,382	29,092	161,474	-16,784	144,690	90.00
91.00	09100	EMERGENCY	1,791,728	1,210,033	3,001,761	-320,092	2,681,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,052,496	43,088,194	55,140,690	8,212	55,148,902	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,032,063	1,708,116	2,740,179	-20	2,740,159	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	192,771	167,820	360,591	0	360,591	194.01
194.02	07952	COMMUNITY IND HEALTH	235,736	71,599	307,335	-8,192	299,143	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	13,513,066	45,035,729	58,548,795	0	58,548,795	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	373,793	5,849,316		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	59,214		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-59,880	3,790,565		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,124,404	12,191,721		5.00
7.00	00700	OPERATION OF PLANT	0	1,349,516		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,700	138,480		8.00
9.00	00900	HOUSEKEEPING	0	541,062		9.00
10.00	01000	DIETARY	-69,504	232,830		10.00
11.00	01100	CAFETERIA	-95,071	152,557		11.00
13.00	01300	NURSING ADMINISTRATION	155,653	617,033		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-104,621	110,881		14.00
15.00	01500	PHARMACY	71,031	488,495		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	482,980	482,980		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,752,542		30.00
31.00	03100	INTENSIVE CARE UNIT	0	814,381		31.00
40.00	04000	SUBPROVIDER - IPF	-164,534	968,683		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-36,435	1,978,951		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-30,897	1,246,413		54.00
54.01	05401	ULTRASOUND	0	215,392		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-599,865	608,148		55.00
56.00	05600	RADIOISOTOPE	0	82,370		56.00
60.00	06000	LABORATORY	-5,716	2,764,118		60.00
65.00	06500	RESPIRATORY THERAPY	-1,944	617,230		65.00
66.00	06600	PHYSICAL THERAPY	0	666,821		66.00
69.00	06900	ELECTROCARDIOLOGY	-460	322,664		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,807,292		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	769,152		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,447,207		73.00
76.00	03020	ACUPUNCTURE	0	43,955		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	144,690		90.00
91.00	09100	EMERGENCY	-421,851	2,259,818		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,634,425	52,514,477		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,740,159		192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	360,591		194.01
194.02	07952	COMMUNITY IND HEALTH	0	299,143		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,634,425	55,914,370		200.00

RECLASSIFICATIONS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/29/2021 2:22 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAP				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	43,067	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		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	43,067	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,199,838	1.00
	0		0	1,199,838	
	C - DIETARY				
1.00	CAFETERIA	11.00	161,369	86,259	1.00
	0		161,369	86,259	
	D - CHARGEABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,807,292	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		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	1,807,292	
	E - DRUGS CHARGED TO PTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,447,207	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		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	9,447,207	
	F - PROTHESIS & IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	769,152	1.00
2.00		0.00	0	0	2.00
	0		0	769,152	
	G - SHARED SERVICES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	66,065	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	518,708	0	2.00
3.00	NURSING ADMINISTRATION	13.00	252,965	0	3.00
	0		837,738	0	
	H - RT ADMIN				
1.00	RESPIRATORY THERAPY	65.00	67,891	0	1.00
	0		67,891	0	
500.00	Grand Total: Increases		1,066,998	13,352,815	500.00

RECLASSIFICATIONS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/29/2021 2:22 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,462	9	1.00
2.00	OPERATION OF PLANT	7.00	0	6,952	9	2.00
3.00	DIETARY	10.00	0	1,054	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,026	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,673	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	2,997	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	3	0	7.00
8.00	OPERATING ROOM	50.00	0	12,382	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	519	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	549	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	445	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	1,041	0	12.00
13.00	EMERGENCY	91.00	0	4,058	0	13.00
14.00	PHARMACY	15.00	0	660	0	14.00
15.00	LABORATORY	60.00	0	246	0	15.00
	0		0	43,067		
	B - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,199,838	11	1.00
	0		0	1,199,838		
	C - DIETARY					
1.00	DIETARY	10.00	161,369	86,259	0	1.00
	0		161,369	86,259		
	D - CHARGEABLE SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56,249	0	1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	229	0	2.00
3.00	HOUSEKEEPING	9.00	0	3,988	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	56,111	0	4.00
5.00	PHARMACY	15.00	0	31,238	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	60,529	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	22,636	0	7.00
8.00	SUBPROVIDER - IPF	40.00	0	9,966	0	8.00
9.00	OPERATING ROOM	50.00	0	1,102,264	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	114,177	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	8,091	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	64,219	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	8,767	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	37,830	0	14.00
15.00	CLINIC	90.00	0	16,784	0	15.00
16.00	EMERGENCY	91.00	0	203,971	0	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20	0	17.00
18.00	COMMUNITY IND HEALTH	194.02	0	8,192	0	18.00
19.00	DIETARY	10.00	0	2,031	0	19.00
	0		0	1,807,292		
	E - DRUGS CHARGED TO PTS					
1.00	PHARMACY	15.00	0	1,066,207	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,837	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	644	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	51	0	4.00
5.00	OPERATING ROOM	50.00	0	12,830	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,284	0	6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	8,255,076	0	7.00
8.00	RADIOISOTOPE	56.00	0	90,318	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	115	0	9.00
10.00	EMERGENCY	91.00	0	4,496	0	10.00
11.00	ADMINISTRATIVE & GENERAL	5.00	0	1,915	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	324	0	12.00
13.00	DIETARY	10.00	0	110	0	13.00
	0		0	9,447,207		
	F - PROTHESIS & IMPLANTS					
1.00	OPERATING ROOM	50.00	0	661,585	0	1.00
2.00	EMERGENCY	91.00	0	107,567	0	2.00
	0		0	769,152		
	G - SHARED SERVICES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	66,065	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	518,708	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	252,965	0	3.00
	0		0	837,738		
	H - RT ADMIN					
1.00	ELECTROCARDIOLOGY	69.00	67,891	0	0	1.00
	0		67,891	0		
500.00	Grand Total: Decreases		229,260	14,190,553		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	970,120	0	0	0	0	1.00
2.00	Land Improvements	3,798,810	0	0	0	45,699	2.00
3.00	Buildings and Fixtures	37,990,625	0	0	0	399,922	3.00
4.00	Building Improvements	6,504,856	1,417,711	0	1,417,711	36,783	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	25,051,375	2,604,696	0	2,604,696	4,833,315	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,315,786	4,022,407	0	4,022,407	5,315,719	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	74,315,786	4,022,407	0	4,022,407	5,315,719	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	970,120	0	1.00
2.00	Land Improvements	3,753,111	0	2.00
3.00	Buildings and Fixtures	37,590,703	0	3.00
4.00	Building Improvements	7,885,784	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	22,822,756	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73,022,474	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	73,022,474	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/29/2021 2:22 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,262,905	12,780	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,147	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,262,905	28,927	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,275,685	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,147	2.00
3.00	Total (sum of lines 1-2)	0	4,291,832	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/29/2021 2:22 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	45,476,488	0	45,476,488	0.665842	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,822,755	0	22,822,755	0.334158	0	2.00
3.00	Total (sum of lines 1-2)	68,299,243	0	68,299,243	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,294,135	355,343	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	43,067	16,147	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,337,202	371,490	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,199,838	0	0	0	5,849,316	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	59,214	2.00
3.00	Total (sum of lines 1-2)	1,199,838	0	0	0	5,908,530	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 2:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-43,247	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-70,723	CENTRAL SERVICES & SUPPLY	14.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,258,942			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,319,639			0	12.00
13.00	Laundry and linen service	B	-2,700	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-95,071	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	0	ADMINISTRATIVE & GENERAL	5.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-268	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-5,001	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-20,805	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/29/2021 2:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-46,397	DIETARY	10.00	0	33.01
33.02	MISC INCOME	B	-12	SUBPROVIDER - IPF	40.00	0	33.02
33.04	MEDICAL OFFICE RENTAL	B	-21,034	RADIOLOGY-THERAPEUTIC	55.00	0	33.04
33.05	DISCOUNTS EARNED/REBATES	B	-28,368	OPERATING ROOM	50.00	0	33.05
33.06	DISCOUNTS EARNED/REBATES	B	-33,898	CENTRAL SERVICES & SUPPLY	14.00	0	33.06
33.07	DISCOUNTS EARNED/REBATES	B	-5,716	LABORATORY	60.00	0	33.07
33.08	HAF ASSESSMENT	A	-3,174,550	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PENSION ADJ	A	-90,228	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	DISCOUNTS EARNED/REBATES	B	-460	ELECTROCARDIOLOGY	69.00	0	33.10
33.11	DISCOUNTS EARNED/REBATES	B	-14,628	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	DISCOUNTS EARNED/REBATES	B	-1,944	RESPIRATORY THERAPY	65.00	0	33.12
33.13	DISCOUNTS EARNED/REBATES	B	-18,106	DIETARY	10.00	0	33.13
33.14	DISCOUNTS EARNED/REBATES	B	-21,966	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,634,425				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/29/2021 2:22 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-INT	1,542,401	1,199,838	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	782,599	751,369	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA A&G	7,750,774	7,507,539	3.00
4.00	15.00	PHARMACY	PHARMACY	71,031	0	4.00
4.04	16.00	MEDICAL RECORDS & LIBRARY	FA-HIM	482,980	0	4.04
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICES	127,008	186,888	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	FSEH SHARED SERVICES	1,208,827	156,000	4.08
4.09	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICES	334,249	178,596	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,299,869	9,980,230	5.00

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

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

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

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

6.00	B	HOME OFFICE	100.00		0.00	6.00
7.00	G	SISTER FACILITY	100.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	SISTER FACILITY				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 7/29/2021 2:22 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	342,563	10		1.00
2.00	31,230	9		2.00
3.00	243,235	0		3.00
4.00	71,031	0		4.00
4.04	482,980	0		4.04
4.07	-59,880	0		4.07
4.08	1,052,827	0		4.08
4.09	155,653	0		4.09
5.00	2,319,639			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/29/2021 2:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	69,402	69,402	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	164,522	164,522	0	0	0	2.00
3.00	50.00	OPERATING ROOM	8,067	8,067	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	16,269	16,269	0	0	0	4.00
5.00	55.00	RADIOLOGY-THERAPEUTIC	578,831	578,831	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	421,851	421,851	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,258,942	1,258,942	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	69,402		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	164,522		2.00
3.00	50.00	OPERATING ROOM	0	0	0	8,067		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	16,269		4.00
5.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	578,831		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	90.00	CLINIC	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	421,851		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,258,942		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,849,316	5,849,316				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	59,214		59,214			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,790,565	33,836	343	3,824,744		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,191,721	710,316	7,191	355,033	13,264,261	5.00
7.00	00700	OPERATION OF PLANT	1,349,516	371,771	3,764	90,281	1,815,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138,480	144,796	1,466	3,396	288,138	8.00
9.00	00900	HOUSEKEEPING	541,062	11,559	117	0	552,738	9.00
10.00	01000	DIETARY	232,830	144,188	1,460	53,254	431,732	10.00
11.00	01100	CAFETERIA	152,557	79,090	801	43,618	276,066	11.00
13.00	01300	NURSING ADMINISTRATION	617,033	47,407	480	139,370	804,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,881	264,929	2,682	16,566	395,058	14.00
15.00	01500	PHARMACY	488,495	14,040	142	92,298	594,975	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	482,980	90,556	917	0	574,453	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,752,542	736,056	7,451	356,545	2,852,594	30.00
31.00	03100	INTENSIVE CARE UNIT	814,381	87,935	890	184,911	1,088,117	31.00
40.00	04000	SUBPROVIDER - IPF	968,683	201,704	2,042	287,749	1,460,178	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,978,951	293,570	2,972	371,753	2,647,246	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,246,413	724,355	7,333	301,324	2,279,425	54.00
54.01	05401	ULTRASOUND	215,392	13,151	133	20,472	249,148	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	608,148	345,845	3,501	143,194	1,100,688	55.00
56.00	05600	RADIOISOTOPE	82,370	12,495	126	22,258	117,249	56.00
60.00	06000	LABORATORY	2,764,118	252,060	2,552	0	3,018,730	60.00
65.00	06500	RESPIRATORY THERAPY	617,230	19,000	192	166,135	802,557	65.00
66.00	06600	PHYSICAL THERAPY	666,821	108,995	1,103	163,678	940,597	66.00
69.00	06900	ELECTROCARDIOLOGY	322,664	15,116	153	86,182	424,115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,807,292	66,080	669	0	1,874,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	769,152	0	0	0	769,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,447,207	199,879	2,023	0	9,649,109	73.00
76.00	03020	ACUPUNCTURE	43,955	0	0	11,855	55,810	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	144,690	39,826	403	35,783	220,702	90.00
91.00	09100	EMERGENCY	2,259,818	535,381	5,420	484,298	3,284,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,514,477	5,563,936	56,326	3,429,953	51,831,418	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,426	166	0	16,592	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,740,159	0	0	278,966	3,019,125	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	192,952	1,953	0	194,905	194.00
194.01	07951	SPORTS MEDICINE	360,591	0	0	52,106	412,697	194.01
194.02	07952	COMMUNITY IND HEALTH	299,143	76,002	769	63,719	439,633	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,914,370	5,849,316	59,214	3,824,744	55,914,370	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,264,261					5.00
7.00	00700	OPERATION OF PLANT	564,572	2,379,904				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,611	72,802	450,551			8.00
9.00	00900	HOUSEKEEPING	171,903	5,812	49,950	780,403		9.00
10.00	01000	DIETARY	134,270	72,496	3,028	24,585	666,111	10.00
11.00	01100	CAFETERIA	85,857	39,766	0	13,485	0	11.00
13.00	01300	NURSING ADMINISTRATION	250,136	23,836	0	8,083	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	122,864	133,204	1,663	45,171	0	14.00
15.00	01500	PHARMACY	185,038	7,059	0	2,394	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178,656	45,531	0	15,440	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	887,162	370,081	136,630	125,501	405,951	30.00
31.00	03100	INTENSIVE CARE UNIT	338,407	44,213	12,815	14,993	69,557	31.00
40.00	04000	SUBPROVIDER - IPF	454,118	101,415	42,027	34,391	190,603	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	823,299	147,604	60,193	50,055	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	708,906	364,199	16,748	123,505	0	54.00
54.01	05401	ULTRASOUND	77,486	6,612	0	2,242	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	342,316	173,887	0	58,968	0	55.00
56.00	05600	RADIOISOTOPE	36,465	6,283	0	2,131	0	56.00
60.00	06000	LABORATORY	938,831	126,733	0	42,977	0	60.00
65.00	06500	RESPIRATORY THERAPY	249,597	9,553	2,320	3,240	0	65.00
66.00	06600	PHYSICAL THERAPY	292,528	54,802	11,706	18,584	0	66.00
69.00	06900	ELECTROCARDIOLOGY	131,901	7,600	0	2,577	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	582,830	33,224	0	11,267	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	239,208	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,000,881	100,497	0	34,080	0	73.00
76.00	03020	ACUPUNCTURE	17,357	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	68,639	20,024	0	6,790	0	90.00
91.00	09100	EMERGENCY	1,021,616	269,184	113,471	91,285	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,994,454	2,236,417	450,551	731,744	666,111	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,160	8,259	0	2,801	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	938,954	0	0	0	0	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	60,616	97,015	0	32,899	0	194.00
194.01	07951	SPORTS MEDICINE	128,350	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	136,727	38,213	0	12,959	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,264,261	2,379,904	450,551	780,403	666,111	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	415,174					11.00
13.00	01300	NURSING ADMINISTRATION	9,975	1,096,320				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,736	76	700,772			14.00
15.00	01500	PHARMACY	14,900	0	0	804,366		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9,347	823,427	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,746	274,676	0	101,746	29,399	30.00
31.00	03100	INTENSIVE CARE UNIT	21,791	124,592	0	31,273	7,574	31.00
40.00	04000	SUBPROVIDER - IPF	35,771	150,995	0	49,341	10,660	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,756	183,487	0	105,714	88,497	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,587	209	0	95,685	112,926	54.00
54.01	05401	ULTRASOUND	2,139	0	0	5,780	16,069	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	24,378	39,029	0	69,007	20,059	55.00
56.00	05600	RADIOISOTOPE	2,413	0	0	13,699	10,346	56.00
60.00	06000	LABORATORY	0	0	0	38,892	83,385	60.00
65.00	06500	RESPIRATORY THERAPY	19,925	0	0	0	8,352	65.00
66.00	06600	PHYSICAL THERAPY	17,960	0	0	25,801	15,475	66.00
69.00	06900	ELECTROCARDIOLOGY	15,796	4,090	0	63,937	23,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	490,540	0	44,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	210,232	0	19,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	181,009	73.00
76.00	03020	ACUPUNCTURE	1,294	7,766	0	0	28	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,055	0	0	0	2,947	90.00
91.00	09100	EMERGENCY	69,952	290,153	0	102,969	149,158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,174	1,075,073	700,772	713,191	823,427	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	91,175	0	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	0	21,247	0	0	0	194.02
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)	415,174	1,096,320	700,772	804,366	823,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,244,486	0	5,244,486		30.00
31.00	03100	INTENSIVE CARE UNIT	1,753,332	0	1,753,332		31.00
40.00	04000	SUBPROVIDER - IPF	2,529,499	0	2,529,499		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,174,851	0	4,174,851		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,744,190	0	3,744,190		54.00
54.01	05401	ULTRASOUND	359,476	0	359,476		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,828,332	0	1,828,332		55.00
56.00	05600	RADIOISOTOPE	188,586	0	188,586		56.00
60.00	06000	LABORATORY	4,249,548	0	4,249,548		60.00
65.00	06500	RESPIRATORY THERAPY	1,095,544	0	1,095,544		65.00
66.00	06600	PHYSICAL THERAPY	1,377,453	0	1,377,453		66.00
69.00	06900	ELECTROCARDIOLOGY	673,864	0	673,864		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,036,419	0	3,036,419		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,237,770	0	1,237,770		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,965,576	0	12,965,576		73.00
76.00	03020	ACUPUNCTURE	82,255	0	82,255		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	323,157	0	323,157		90.00
91.00	09100	EMERGENCY	5,392,705	0	5,392,705		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,257,043	0	50,257,043		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,812	0	32,812		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,049,254	0	4,049,254		192.00
194.00	07953	OTHER NONREIMB COST CENTERS	385,435	0	385,435		194.00
194.01	07951	SPORTS MEDICINE	541,047	0	541,047		194.01
194.02	07952	COMMUNITY IND HEALTH	648,779	0	648,779		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	55,914,370	0	55,914,370		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,836	343	34,179	34,179	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	710,316	7,191	717,507	3,172	5.00
7.00	00700	OPERATION OF PLANT	0	371,771	3,764	375,535	807	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,796	1,466	146,262	30	8.00
9.00	00900	HOUSEKEEPING	0	11,559	117	11,676	0	9.00
10.00	01000	DIETARY	0	144,188	1,460	145,648	476	10.00
11.00	01100	CAFETERIA	0	79,090	801	79,891	390	11.00
13.00	01300	NURSING ADMINISTRATION	0	47,407	480	47,887	1,245	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	264,929	2,682	267,611	148	14.00
15.00	01500	PHARMACY	0	14,040	142	14,182	825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	90,556	917	91,473	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	736,056	7,451	743,507	3,186	30.00
31.00	03100	INTENSIVE CARE UNIT	0	87,935	890	88,825	1,652	31.00
40.00	04000	SUBPROVIDER - IPF	0	201,704	2,042	203,746	2,571	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	293,570	2,972	296,542	3,321	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	724,355	7,333	731,688	2,692	54.00
54.01	05401	ULTRASOUND	0	13,151	133	13,284	183	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	345,845	3,501	349,346	1,279	55.00
56.00	05600	RADIOISOTOPE	0	12,495	126	12,621	199	56.00
60.00	06000	LABORATORY	0	252,060	2,552	254,612	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,000	192	19,192	1,484	65.00
66.00	06600	PHYSICAL THERAPY	0	108,995	1,103	110,098	1,462	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,116	153	15,269	770	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	66,080	669	66,749	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	199,879	2,023	201,902	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	106	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	39,826	403	40,229	320	90.00
91.00	09100	EMERGENCY	0	535,381	5,420	540,801	4,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,563,936	56,326	5,620,262	30,652	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,426	166	16,592	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,492	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	192,952	1,953	194,905	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	466	194.01
194.02	07952	COMMUNITY IND HEALTH	0	76,002	769	76,771	569	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,849,316	59,214	5,908,530	34,179	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	720,679					5.00
7.00	00700	OPERATION OF PLANT	30,674	407,016				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,869	12,451	163,612			8.00
9.00	00900	HOUSEKEEPING	9,340	994	18,139	40,149		9.00
10.00	01000	DIETARY	7,295	12,398	1,099	1,265	168,181	10.00
11.00	01100	CAFETERIA	4,665	6,801	0	694	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,590	4,076	0	416	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,675	22,781	604	2,324	0	14.00
15.00	01500	PHARMACY	10,053	1,207	0	123	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,707	7,787	0	794	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,200	63,293	49,615	6,456	102,495	30.00
31.00	03100	INTENSIVE CARE UNIT	18,386	7,561	4,654	771	17,562	31.00
40.00	04000	SUBPROVIDER - IPF	24,673	17,344	15,262	1,769	48,124	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,731	25,244	21,858	2,575	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,515	62,286	6,082	6,354	0	54.00
54.01	05401	ULTRASOUND	4,210	1,131	0	115	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	18,598	29,739	0	3,034	0	55.00
56.00	05600	RADIOISOTOPE	1,981	1,074	0	110	0	56.00
60.00	06000	LABORATORY	51,007	21,674	0	2,211	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,561	1,634	842	167	0	65.00
66.00	06600	PHYSICAL THERAPY	15,893	9,372	4,251	956	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,166	1,300	0	133	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,666	5,682	0	580	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,996	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,063	17,187	0	1,753	0	73.00
76.00	03020	ACUPUNCTURE	943	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,729	3,425	0	349	0	90.00
91.00	09100	EMERGENCY	55,505	46,036	41,206	4,696	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	651,691	382,477	163,612	37,645	168,181	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	280	1,412	0	144	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,014	0	0	0	0	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	3,293	16,592	0	1,693	0	194.00
194.01	07951	SPORTS MEDICINE	6,973	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	7,428	6,535	0	667	0	194.02
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)	720,679	407,016	163,612	40,149	168,181	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	92,441					11.00
13.00	01300	NURSING ADMINISTRATION	2,221	69,435				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	609	5	300,757			14.00
15.00	01500	PHARMACY	3,318	0	0	29,708		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	345	110,106	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,526	17,398	0	3,758	3,934	30.00
31.00	03100	INTENSIVE CARE UNIT	4,852	7,892	0	1,155	1,013	31.00
40.00	04000	SUBPROVIDER - IPF	7,965	9,564	0	1,822	1,426	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,309	11,622	0	3,906	11,841	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,482	13	0	3,534	15,110	54.00
54.01	05401	ULTRASOUND	476	0	0	213	2,150	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,428	2,472	0	2,549	2,684	55.00
56.00	05600	RADIOISOTOPE	537	0	0	506	1,384	56.00
60.00	06000	LABORATORY	0	0	0	1,436	11,157	60.00
65.00	06500	RESPIRATORY THERAPY	4,437	0	0	0	1,117	65.00
66.00	06600	PHYSICAL THERAPY	3,999	0	0	953	2,071	66.00
69.00	06900	ELECTROCARDIOLOGY	3,517	259	0	2,361	3,191	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	210,530	0	5,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	90,227	0	2,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	24,149	73.00
76.00	03020	ACUPUNCTURE	288	492	0	0	4	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	903	0	0	0	394	90.00
91.00	09100	EMERGENCY	15,574	18,372	0	3,803	19,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,441	68,089	300,757	26,341	110,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	3,367	0	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	0	1,346	0	0	0	194.02
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)	92,441	69,435	300,757	29,708	110,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,055,368	0	1,055,368		30.00
31.00	03100	INTENSIVE CARE UNIT	154,323	0	154,323		31.00
40.00	04000	SUBPROVIDER - IPF	334,266	0	334,266		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	436,949	0	436,949		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,756	0	875,756		54.00
54.01	05401	ULTRASOUND	21,762	0	21,762		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	415,129	0	415,129		55.00
56.00	05600	RADIOISOTOPE	18,412	0	18,412		56.00
60.00	06000	LABORATORY	342,097	0	342,097		60.00
65.00	06500	RESPIRATORY THERAPY	42,434	0	42,434		65.00
66.00	06600	PHYSICAL THERAPY	149,055	0	149,055		66.00
69.00	06900	ELECTROCARDIOLOGY	33,966	0	33,966		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,164	0	321,164		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,789	0	105,789		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	408,054	0	408,054		73.00
76.00	03020	ACUPUNCTURE	1,833	0	1,833		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	49,349	0	49,349		90.00
91.00	09100	EMERGENCY	750,285	0	750,285		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,515,991	0	5,515,991		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,428	0	18,428		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,873	0	56,873		192.00
194.00	07953	OTHER NONREIMB COST CENTERS	216,483	0	216,483		194.00
194.01	07951	SPORTS MEDICINE	7,439	0	7,439		194.01
194.02	07952	COMMUNITY IND HEALTH	93,316	0	93,316		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,908,530	0	5,908,530		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	124,988					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		124,988				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	723	723	14,150,069			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,178	15,178	1,313,484	-13,264,261	42,650,109	5.00
7.00	00700	OPERATION OF PLANT	7,944	7,944	334,006	0	1,815,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,094	3,094	12,565	0	288,138	8.00
9.00	00900	HOUSEKEEPING	247	247	0	0	552,738	9.00
10.00	01000	DIETARY	3,081	3,081	197,019	0	431,732	10.00
11.00	01100	CAFETERIA	1,690	1,690	161,369	0	276,066	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	1,013	515,615	0	804,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,661	5,661	61,288	0	395,058	14.00
15.00	01500	PHARMACY	300	300	341,465	0	594,975	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,935	1,935	0	0	574,453	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,728	15,728	1,319,076	0	2,852,594	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	1,879	684,098	0	1,088,117	31.00
40.00	04000	SUBPROVIDER - IPF	4,310	4,310	1,064,559	0	1,460,178	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,273	6,273	1,375,339	0	2,647,246	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,478	15,478	1,114,779	0	2,279,425	54.00
54.01	05401	ULTRASOUND	281	281	75,739	0	249,148	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	7,390	7,390	529,762	0	1,100,688	55.00
56.00	05600	RADIOISOTOPE	267	267	82,344	0	117,249	56.00
60.00	06000	LABORATORY	5,386	5,386	0	0	3,018,730	60.00
65.00	06500	RESPIRATORY THERAPY	406	406	614,636	0	802,557	65.00
66.00	06600	PHYSICAL THERAPY	2,329	2,329	605,545	0	940,597	66.00
69.00	06900	ELECTROCARDIOLOGY	323	323	318,841	0	424,115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412	1,412	0	0	1,874,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	769,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,271	4,271	0	0	9,649,109	73.00
76.00	03020	ACUPUNCTURE	0	0	43,860	0	55,810	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	851	851	132,382	0	220,702	90.00
91.00	09100	EMERGENCY	11,440	11,440	1,791,728	0	3,284,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,890	118,890	12,689,499	-13,264,261	38,567,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	351	0	0	16,592	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,032,063	0	3,019,125	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	4,123	4,123	0	0	194,905	194.00
194.01	07951	SPORTS MEDICINE	0	0	192,771	0	412,697	194.01
194.02	07952	COMMUNITY IND HEALTH	1,624	1,624	235,736	0	439,633	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,849,316	59,214	3,824,744		13,264,261	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.799021	0.473757	0.270299		0.311002	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			34,179		720,679	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002415		0.016897	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	101,143					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,094	187,211				8.00
9.00	00900	HOUSEKEEPING	247	20,755	97,802			9.00
10.00	01000	DIETARY	3,081	1,258	3,081	19,354		10.00
11.00	01100	CAFETERIA	1,690	0	1,690	0	16,690	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	0	1,013	0	401	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,661	691	5,661	0	110	14.00
15.00	01500	PHARMACY	300	0	300	0	599	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,935	0	1,935	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,728	56,772	15,728	11,795	2,442	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	5,325	1,879	2,021	876	31.00
40.00	04000	SUBPROVIDER - IPF	4,310	17,463	4,310	5,538	1,438	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,273	25,011	6,273	0	2,764	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,478	6,959	15,478	0	1,712	54.00
54.01	05401	ULTRASOUND	281	0	281	0	86	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	7,390	0	7,390	0	980	55.00
56.00	05600	RADIOISOTOPE	267	0	267	0	97	56.00
60.00	06000	LABORATORY	5,386	0	5,386	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	406	964	406	0	801	65.00
66.00	06600	PHYSICAL THERAPY	2,329	4,864	2,329	0	722	66.00
69.00	06900	ELECTROCARDIOLOGY	323	0	323	0	635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412	0	1,412	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,271	0	4,271	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	52	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	851	0	851	0	163	90.00
91.00	09100	EMERGENCY	11,440	47,149	11,440	0	2,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,045	187,211	91,704	19,354	16,690	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	0	351	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07953	OTHER NONREIMB COST CENTERS	4,123	0	4,123	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	1,624	0	1,624	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,379,904	450,551	780,403	666,111	415,174	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.530091	2.406648	7.979418	34.417226	24.875614	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	407,016	163,612	40,149	168,181	92,441	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.024164	0.873944	0.410513	8.689728	5.538706	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/29/2021 2:22 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,211,655					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,050	100				14.00
15.00	01500	PHARMACY	0	0	86,140			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,001	224,860,228		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,811,183	0	10,896	8,028,135		30.00
31.00	03100	INTENSIVE CARE UNIT	1,728,733	0	3,349	2,068,205		31.00
40.00	04000	SUBPROVIDER - IPF	2,095,087	0	5,284	2,911,108		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,545,922	0	11,321	24,166,175		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,894	0	10,247	30,837,279		54.00
54.01	05401	ULTRASOUND	0	0	619	4,388,043		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	541,535	0	7,390	5,477,551		55.00
56.00	05600	RADIOISOTOPE	0	0	1,467	2,825,359		56.00
60.00	06000	LABORATORY	0	0	4,165	22,770,244		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,280,595		65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,763	4,225,920		66.00
69.00	06900	ELECTROCARDIOLOGY	56,750	0	6,847	6,512,170		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	70	0	12,156,499		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30	0	5,237,108		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,432,363		73.00
76.00	03020	ACUPUNCTURE	107,750	0	0	7,511		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	804,750		90.00
91.00	09100	EMERGENCY	4,025,951	0	11,027	40,731,213		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,916,855	100	76,376	224,860,228		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,764	0		192.00
194.00	07953	OTHER NONREIMB COST CENTERS	0	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0		194.01
194.02	07952	COMMUNITY IND HEALTH	294,800	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,096,320	700,772	804,366	823,427		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.072071	7,007.720000	9.337892	0.003662		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	69,435	300,757	29,708	110,106		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004565	3,007.570000	0.344880	0.000490		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:22 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,244,486		5,244,486	0	5,244,486	30.00
31.00	03100	INTENSIVE CARE UNIT	1,753,332		1,753,332	0	1,753,332	31.00
40.00	04000	SUBPROVIDER - IPF	2,529,499		2,529,499	0	2,529,499	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,174,851		4,174,851	0	4,174,851	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,744,190		3,744,190	0	3,744,190	54.00
54.01	05401	ULTRASOUND	359,476		359,476	0	359,476	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,828,332		1,828,332	0	1,828,332	55.00
56.00	05600	RADIOISOTOPE	188,586		188,586	0	188,586	56.00
60.00	06000	LABORATORY	4,249,548		4,249,548	0	4,249,548	60.00
65.00	06500	RESPIRATORY THERAPY	1,095,544	0	1,095,544	0	1,095,544	65.00
66.00	06600	PHYSICAL THERAPY	1,377,453	0	1,377,453	0	1,377,453	66.00
69.00	06900	ELECTROCARDIOLOGY	673,864		673,864	0	673,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,036,419		3,036,419	0	3,036,419	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,237,770		1,237,770	0	1,237,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,965,576		12,965,576	0	12,965,576	73.00
76.00	03020	ACUPUNCTURE	82,255		82,255	0	82,255	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	323,157		323,157	0	323,157	90.00
91.00	09100	EMERGENCY	5,392,705		5,392,705	0	5,392,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,540,549		1,540,549		1,540,549	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	51,797,592	0	51,797,592	0	51,797,592	200.00
201.00		Less Observation Beds	1,540,549		1,540,549		1,540,549	201.00
202.00		Total (see instructions)	50,257,043	0	50,257,043	0	50,257,043	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:22 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,523,927		5,523,927			30.00
31.00	03100	INTENSIVE CARE UNIT	2,068,205		2,068,205			31.00
40.00	04000	SUBPROVIDER - IPF	2,911,108		2,911,108			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,152,215	19,013,960	24,166,175	0.172756	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,314,765	27,522,514	30,837,279	0.121418	0.000000	54.00
54.01	05401	ULTRASOUND	470,408	3,917,635	4,388,043	0.081922	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	8,505	5,469,046	5,477,551	0.333786	0.000000	55.00
56.00	05600	RADIOISOTOPE	113,496	2,711,863	2,825,359	0.066748	0.000000	56.00
60.00	06000	LABORATORY	4,163,389	18,606,855	22,770,244	0.186627	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,418,708	861,887	2,280,595	0.480376	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	824,104	3,401,816	4,225,920	0.325953	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	810,396	5,701,774	6,512,170	0.103478	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,829,701	8,326,798	12,156,499	0.249777	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,165,214	3,071,894	5,237,108	0.236346	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,498,270	46,934,093	49,432,363	0.262289	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	7,511	7,511	10.951271	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,300	799,450	804,750	0.401562	0.000000	90.00
91.00	09100	EMERGENCY	3,799,810	36,931,403	40,731,213	0.132397	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	675,564	1,828,644	2,504,208	0.615184	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,753,085	185,107,143	224,860,228			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,753,085	185,107,143	224,860,228			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:22 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.172756		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121418		54.00
54.01	05401	ULTRASOUND	0.081922		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.333786		55.00
56.00	05600	RADIOISOTOPE	0.066748		56.00
60.00	06000	LABORATORY	0.186627		60.00
65.00	06500	RESPIRATORY THERAPY	0.480376		65.00
66.00	06600	PHYSICAL THERAPY	0.325953		66.00
69.00	06900	ELECTROCARDIOLOGY	0.103478		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249777		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.236346		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262289		73.00
76.00	03020	ACUPUNCTURE	10.951271		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.401562		90.00
91.00	09100	EMERGENCY	0.132397		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.615184		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,244,486		5,244,486	0	5,244,486	30.00
31.00	03100	INTENSIVE CARE UNIT	1,753,332		1,753,332	0	1,753,332	31.00
40.00	04000	SUBPROVIDER - IPF	2,529,499		2,529,499	0	2,529,499	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,174,851		4,174,851	0	4,174,851	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,744,190		3,744,190	0	3,744,190	54.00
54.01	05401	ULTRASOUND	359,476		359,476	0	359,476	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,828,332		1,828,332	0	1,828,332	55.00
56.00	05600	RADIOISOTOPE	188,586		188,586	0	188,586	56.00
60.00	06000	LABORATORY	4,249,548		4,249,548	0	4,249,548	60.00
65.00	06500	RESPIRATORY THERAPY	1,095,544	0	1,095,544	0	1,095,544	65.00
66.00	06600	PHYSICAL THERAPY	1,377,453	0	1,377,453	0	1,377,453	66.00
69.00	06900	ELECTROCARDIOLOGY	673,864		673,864	0	673,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,036,419		3,036,419	0	3,036,419	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,237,770		1,237,770	0	1,237,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,965,576		12,965,576	0	12,965,576	73.00
76.00	03020	ACUPUNCTURE	82,255		82,255	0	82,255	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	323,157		323,157	0	323,157	90.00
91.00	09100	EMERGENCY	5,392,705		5,392,705	0	5,392,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,540,549		1,540,549		1,540,549	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	51,797,592	0	51,797,592	0	51,797,592	200.00
201.00		Less Observation Beds	1,540,549		1,540,549		1,540,549	201.00
202.00		Total (see instructions)	50,257,043	0	50,257,043	0	50,257,043	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,523,927		5,523,927			30.00
31.00	03100	INTENSIVE CARE UNIT	2,068,205		2,068,205			31.00
40.00	04000	SUBPROVIDER - IPF	2,911,108		2,911,108			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,152,215	19,013,960	24,166,175	0.172756	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,314,765	27,522,514	30,837,279	0.121418	0.000000	54.00
54.01	05401	ULTRASOUND	470,408	3,917,635	4,388,043	0.081922	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	8,505	5,469,046	5,477,551	0.333786	0.000000	55.00
56.00	05600	RADIOISOTOPE	113,496	2,711,863	2,825,359	0.066748	0.000000	56.00
60.00	06000	LABORATORY	4,163,389	18,606,855	22,770,244	0.186627	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,418,708	861,887	2,280,595	0.480376	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	824,104	3,401,816	4,225,920	0.325953	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	810,396	5,701,774	6,512,170	0.103478	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,829,701	8,326,798	12,156,499	0.249777	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,165,214	3,071,894	5,237,108	0.236346	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,498,270	46,934,093	49,432,363	0.262289	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	7,511	7,511	10.951271	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,300	799,450	804,750	0.401562	0.000000	90.00
91.00	09100	EMERGENCY	3,799,810	36,931,403	40,731,213	0.132397	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	675,564	1,828,644	2,504,208	0.615184	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,753,085	185,107,143	224,860,228			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,753,085	185,107,143	224,860,228			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/29/2021 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,055,368	0	1,055,368	3,966	266.10	30.00
31.00	INTENSIVE CARE UNIT	154,323		154,323	480	321.51	31.00
40.00	SUBPROVIDER - IPF	334,266	0	334,266	1,315	254.19	40.00
200.00	Total (lines 30 through 199)	1,543,957		1,543,957	5,761		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,442	383,716	30.00
31.00	INTENSIVE CARE UNIT	163	52,406	31.00
40.00	SUBPROVIDER - IPF	863	219,366	40.00
200.00	Total (lines 30 through 199)	2,468	655,488	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	436,949	24,166,175	0.018081	1,955,060	35,349	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,756	30,837,279	0.028399	1,687,999	47,937	54.00
54.01	05401	ULTRASOUND	21,762	4,388,043	0.004959	49,502	245	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	415,129	5,477,551	0.075787	1,272	96	55.00
56.00	05600	RADIOISOTOPE	18,412	2,825,359	0.006517	58,722	383	56.00
60.00	06000	LABORATORY	342,097	22,770,244	0.015024	1,938,173	29,119	60.00
65.00	06500	RESPIRATORY THERAPY	42,434	2,280,595	0.018607	585,075	10,886	65.00
66.00	06600	PHYSICAL THERAPY	149,055	4,225,920	0.035272	446,586	15,752	66.00
69.00	06900	ELECTROCARDIOLOGY	33,966	6,512,170	0.005216	575,390	3,001	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,164	12,156,499	0.026419	1,406,079	37,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,789	5,237,108	0.020200	991,901	20,036	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	408,054	49,432,363	0.008255	1,351,794	11,159	73.00
76.00	03020	ACUPUNCTURE	1,833	7,511	0.244042	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,349	804,750	0.061322	636	39	90.00
91.00	09100	EMERGENCY	750,285	40,731,213	0.018420	1,602,086	29,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	310,011	2,504,208	0.123796	363,905	45,050	92.00
200.00		Total (lines 50 through 199)	4,282,045	214,356,988		13,014,180	285,709	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,966	0.00	1,442	30.00
31.00	03100	INTENSIVE CARE UNIT		0	480	0.00	163	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,315	0.00	863	40.00
200.00		Total (lines 30 through 199)		0	5,761		2,468	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	24,166,175	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,837,279	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,388,043	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,477,551	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,825,359	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	22,770,244	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,280,595	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,225,920	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,512,170	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,156,499	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,237,108	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,432,363	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	7,511	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	804,750	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,731,213	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,504,208	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	214,356,988		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,955,060	0	4,296,120	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,687,999	0	7,114,454	0	54.00
54.01	05401	ULTRASOUND	0.000000	49,502	0	1,066,037	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	1,272	0	1,894,310	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	58,722	0	1,050,326	0	56.00
60.00	06000	LABORATORY	0.000000	1,938,173	0	300,782	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	585,075	0	275,896	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	446,586	0	9,702	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	575,390	0	2,172,624	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,406,079	0	1,819,637	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	991,901	0	666,751	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,351,794	0	18,730,846	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	7,511	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	636	0	204,464	0	90.00
91.00	09100	EMERGENCY	0.000000	1,602,086	0	6,929,797	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	363,905	0	920,796	0	92.00
200.00		Total (lines 50 through 199)		13,014,180	0	47,460,053	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.172756	4,296,120	0	0	742,181	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121418	7,114,454	0	0	863,823	54.00
54.01	05401	ULTRASOUND	0.081922	1,066,037	0	0	87,332	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.333786	1,894,310	0	0	632,294	55.00
56.00	05600	RADIOISOTOPE	0.066748	1,050,326	0	0	70,107	56.00
60.00	06000	LABORATORY	0.186627	300,782	0	0	56,134	60.00
65.00	06500	RESPIRATORY THERAPY	0.480376	275,896	0	0	132,534	65.00
66.00	06600	PHYSICAL THERAPY	0.325953	9,702	0	0	3,162	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103478	2,172,624	0	0	224,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249777	1,819,637	0	0	454,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.236346	666,751	0	0	157,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262289	18,730,846	576	0	4,912,895	73.00
76.00	03020	ACUPUNCTURE	10.951271	7,511	0	0	82,255	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.401562	204,464	0	0	82,105	90.00
91.00	09100	EMERGENCY	0.132397	6,929,797	0	0	917,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.615184	920,796	0	0	566,459	92.00
200.00		Subtotal (see instructions)		47,460,053	576	0	9,985,671	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		47,460,053	576	0	9,985,671	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	151	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	151	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	436,949	24,166,175	0.018081	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,756	30,837,279	0.028399	24,011	682	54.00
54.01	05401	ULTRASOUND	21,762	4,388,043	0.004959	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	415,129	5,477,551	0.075787	0	0	55.00
56.00	05600	RADIOISOTOPE	18,412	2,825,359	0.006517	0	0	56.00
60.00	06000	LABORATORY	342,097	22,770,244	0.015024	169,955	2,553	60.00
65.00	06500	RESPIRATORY THERAPY	42,434	2,280,595	0.018607	40,523	754	65.00
66.00	06600	PHYSICAL THERAPY	149,055	4,225,920	0.035272	35,920	1,267	66.00
69.00	06900	ELECTROCARDIOLOGY	33,966	6,512,170	0.005216	26,691	139	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,164	12,156,499	0.026419	44,954	1,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,789	5,237,108	0.020200	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	408,054	49,432,363	0.008255	68,198	563	73.00
76.00	03020	ACUPUNCTURE	1,833	7,511	0.244042	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,349	804,750	0.061322	0	0	90.00
91.00	09100	EMERGENCY	750,285	40,731,213	0.018420	79,592	1,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,504,208	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,972,034	214,356,988		489,844	8,612	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	24,166,175	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,837,279	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,388,043	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,477,551	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,825,359	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	22,770,244	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,280,595	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,225,920	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,512,170	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,156,499	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,237,108	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,432,363	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	7,511	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	804,750	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,731,213	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,504,208	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	214,356,988		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	24,011	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	169,955	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	40,523	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	35,920	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	26,691	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	44,954	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	68,198	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	79,592	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		489,844	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,966	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,966	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,801	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,442	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,244,486	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,244,486	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,244,486	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,322.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,906,843	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,906,843	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,753,332	480	3,652.78	163	595,403	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,775,412	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,277,658	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	436,122	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	285,709	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	721,831	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,555,827	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,165	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,322.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,540,549	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,055,368	5,244,486	0.201234	1,540,549	310,011	90.00
91.00	Nursing School cost	0	5,244,486	0.000000	1,540,549	0	91.00
92.00	Allied health cost	0	5,244,486	0.000000	1,540,549	0	92.00
93.00	All other Medical Education	0	5,244,486	0.000000	1,540,549	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,315	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,315	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,315	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	863	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,529,499	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,529,499	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,529,499	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,923.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,660,041	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,660,041	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	108,223	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,768,264	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	219,366	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,612	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	227,978	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,540,286	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	334,266	2,529,499	0.132147	0	0	90.00
91.00	Nursing School cost	0	2,529,499	0.000000	0	0	91.00
92.00	Allied health cost	0	2,529,499	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,529,499	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,375,185		30.00
31.00	03100	INTENSIVE CARE UNIT		723,227		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.172756	1,955,060	337,748	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121418	1,687,999	204,953	54.00
54.01	05401	ULTRASOUND	0.081922	49,502	4,055	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.333786	1,272	425	55.00
56.00	05600	RADIOISOTOPE	0.066748	58,722	3,920	56.00
60.00	06000	LABORATORY	0.186627	1,938,173	361,715	60.00
65.00	06500	RESPIRATORY THERAPY	0.480376	585,075	281,056	65.00
66.00	06600	PHYSICAL THERAPY	0.325953	446,586	145,566	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103478	575,390	59,540	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249777	1,406,079	351,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.236346	991,901	234,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262289	1,351,794	354,561	73.00
76.00	03020	ACUPUNCTURE	10.951271	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.401562	636	255	90.00
91.00	09100	EMERGENCY	0.132397	1,602,086	212,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.615184	363,905	223,869	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,014,180	2,775,412	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		13,014,180		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,898,337		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.172756	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121418	24,011	2,915	54.00
54.01	05401	ULTRASOUND	0.081922	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.333786	0	0	55.00
56.00	05600	RADIOISOTOPE	0.066748	0	0	56.00
60.00	06000	LABORATORY	0.186627	169,955	31,718	60.00
65.00	06500	RESPIRATORY THERAPY	0.480376	40,523	19,466	65.00
66.00	06600	PHYSICAL THERAPY	0.325953	35,920	11,708	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103478	26,691	2,762	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249777	44,954	11,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.236346	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262289	68,198	17,888	73.00
76.00	03020	ACUPUNCTURE	10.951271	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.401562	0	0	90.00
91.00	09100	EMERGENCY	0.132397	79,592	10,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.615184	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		489,844	108,223	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		489,844		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,734,641	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,244,950	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	50,818	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	6,416	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	25.82	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)	8.50	31.00
32.00	Sum of lines 30 and 31	10.45	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,036,825		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	3,539,537		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	4,036,825	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	340,936	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	8,395	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	4,386,156	59.00
60.00	Primary payer payments	3,592	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,382,564	61.00
62.00	Deductibles billed to program beneficiaries	522,236	62.00
63.00	Coinsurance billed to program beneficiaries	1,408	63.00
64.00	Allowable bad debts (see instructions)	50,633	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	32,911	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,928	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,891,831	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	30,975	70.93
70.94	HRR adjustment amount (see instructions)	-4,649	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A | Date/Time Prepared: 7/29/2021 2:22 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	738,319	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2020	351,904	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,008,380	71.00
71.01	Sequestration adjustment (see instructions)		33,055	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		5,048,803	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-73,478	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		100,908	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0092712294	1.0044853822	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9983	1.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/29/2021 2:22 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	-58,687	58,687	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,734,641	0	2,734,641		2,734,641	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,244,950	0		1,244,950	1,244,950	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	50,818	0	50,818		50,818	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	6,416	0		6,416	6,416	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,036,825	0	2,726,772	1,310,053	4,036,825	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,036,825	0	2,726,772	1,310,053	4,036,825	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	340,936	0	243,613	97,323	340,936	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/29/2021 2:22 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	8,395	0	0	8,395	8,395	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,970,385	1,415,771	4,386,156	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	308,810	0	216,553	92,257	308,810	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	32,126	0	27,060	5,066	32,126	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	340,936	0	243,613	97,323	340,936	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.248560	0.248560		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			738,319		738,319	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				351,904	351,904	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/29/2021 2:22 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,734,641	2,734,641		2,734,641	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,244,950		1,244,950	1,244,950	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	50,818	50,818		50,818	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	6,416		6,416	6,416	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,036,825	2,785,459	1,251,366	4,036,825	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,036,825	2,785,459	1,251,366	4,036,825	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	340,936	243,613	97,323	340,936	16.00
17.00	Special add-on payments for new technologies	54.00	8,395	0	8,395	8,395	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,029,072	1,357,084	4,386,156	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/29/2021 2:22 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	308,810	216,553	92,257	308,810	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	32,126	27,060	5,066	32,126	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	340,936	243,613	97,323	340,936	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	738,319	738,319		738,319	28.00
29.00	Low volume adjustment on or after October 1	70.97	351,904		351,904	351,904	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	30,975	23,189	7,786	30,975	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,649	-3,480	-1,169	-4,649	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	151	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,985,671	2.00
3.00	OPPS payments	7,012,694	3.00
4.00	Outlier payment (see instructions)	61,360	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	151	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	576	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	576	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	576	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	425	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	151	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	7,074,054	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,291,862	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,782,343	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,782,343	30.00
31.00	Primary payer payments	658	31.00
32.00	Subtotal (line 30 minus line 31)	5,781,685	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	188,224	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	122,346	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	118,134	36.00
37.00	Subtotal (see instructions)	5,904,031	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,904,031	40.00
40.01	Sequestration adjustment (see instructions)	38,967	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,899,031	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-33,967	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,048,803		5,899,031	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,048,803		5,899,031	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		73,478		33,967	6.02
7.00	Total Medicare program liability (see instructions)		4,975,325		5,865,064	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/29/2021 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		833,675		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		833,675		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,390		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		836,065		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	907,708	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	3.592896	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	907,708	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	907,708	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	907,708	18.00
19.00	Deductibles	66,088	19.00
20.00	Subtotal (line 18 minus line 19)	841,620	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	841,620	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	274	25.00
26.00	Subtotal (sum of lines 22 and 24)	841,620	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	841,620	31.00
31.01	Sequestration adjustment (see instructions)	5,555	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	833,675	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	2,390	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/29/2021 2:22 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/29/2021 2:22 pm
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/29/2021 2:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,470	0	0	0	1.00
2.00	Temporary investments	8,304,022	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,999,929	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,253,521	0	0	0	6.00
7.00	Inventory	1,550,049	0	0	0	7.00
8.00	Prepaid expenses	733,808	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,332,817	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	970,120	0	0	0	12.00
13.00	Land improvements	3,753,111	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	44,828,225	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	505,596	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	22,965,422	0	0	0	23.00
24.00	Accumulated depreciation	-37,591,807	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,430,667	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,083,958	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,083,958	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,847,442	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,412,979	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,535,577	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	6,717,070	0	0	0	43.00
44.00	Other current liabilities	469,961	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,135,587	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-2,374,505	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-2,374,505	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,761,082	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	47,086,360				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	47,086,360	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,847,442	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/29/2021 2:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		46,248,932		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,744,343				2.00
3.00	Total (sum of line 1 and line 2)		55,993,275		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		55,993,275		0		11.00
12.00	EQUITY TRANSFERS	13,075,661		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		13,075,661		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		42,917,614		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/29/2021 2:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,523,927		5,523,927	1.00
2.00	SUBPROVIDER - IPF	2,911,108		2,911,108	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,435,035		8,435,035	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,068,205		2,068,205	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,068,205		2,068,205	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,503,240		10,503,240	17.00
18.00	Ancillary services	24,769,171	145,547,646	170,316,817	18.00
19.00	Outpatient services	4,480,674	39,559,497	44,040,171	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	39,753,085	185,107,143	224,860,228	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,548,795		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		58,548,795		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/29/2021 2:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	224,860,228	1.00
2.00	Less contractual allowances and discounts on patients' accounts	162,849,418	2.00
3.00	Net patient revenues (line 1 minus line 2)	62,010,810	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,548,795	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,462,015	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	960	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	168,333	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	2,700	13.00
14.00	Revenue from meals sold to employees and guests	141,418	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	268	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	2,622	20.00
21.00	Rental of vending machines	5,001	21.00
22.00	Rental of hospital space	278,817	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPER REV & NON OPER REV	89,306	24.00
24.50	COVID-19 PHE Funding	5,342,716	24.50
25.00	Total other income (sum of lines 6-24)	6,032,141	25.00
26.00	Total (line 5 plus line 25)	9,494,156	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	EQUITY TRANSFERS	0	27.01
27.02	NON OPERATING REVENUE	-250,187	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	-250,187	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,744,343	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0022	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/29/2021 2:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	308,810	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	32,126	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	8.96	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	340,936	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00