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: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/30/2021 9:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/30/2021 Time: 9:15 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) 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.

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

(Signed) DARIN BROWN
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-7,633	-60,496	0	-106,695	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		748,700		0	10.00
10.01	RURAL HEALTH CLINIC II	0		424,969		0	10.01
10.02	RURAL HEALTH CLINIC III	0		76,764		0	10.02
200.00	Total	0	-7,633	1,189,937	0	-106,695	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/30/2021 9:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 NORTH 16TH STREET	PO Box:			1.00
2.00	City: NEW CASTLE	State: IN	Zip Code: 47392-	County: HENRY	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	HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC	NEW CASTLE FAMILY AND INTERNAL MED	158520	99915		04/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	NCFIM - NORHTFIELD PARK	158525	99915		12/04/2017	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMBRIDGE CITY FAMILY HEALTH PARTNER	158556	99915		06/02/2020	N	O	O	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/30/2021 9:15 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	232	1,130	0	0	470	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 9:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 9:15 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 9:15 am

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	793,332	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/30/2021 9:15 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 9:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/30/2021 9:15 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/04/2021	Y	05/04/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 9:15 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 9:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/30/2021 9:15 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,908	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)		38	13,908	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		48	17,568	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		48				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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/30/2021 9:15 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,568	229	6,415			1.00
2.00	HMO and other (see instructions)	1,765	1,552				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,568	229	6,415			7.00
8.00	INTENSIVE CARE UNIT	623	0	1,391			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	559			13.00
14.00	Total (see instructions)	3,191	229	8,365	0.00	363.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,473	269	11,965	0.00	13.20	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	5.64	24.00
24.10	HOSPICE (non-distinct part)			43			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,914	2,975	20,102	0.00	52.34	26.00
26.01	RURAL HEALTH CLINIC II	6,181	14,902	46,656	0.00	83.28	26.01
26.02	RURAL HEALTH CLINIC III	248	347	1,879	0.00	4.58	26.02
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	522.24	27.00
28.00	Observation Bed Days		170	891			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	51	92			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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/30/2021 9:15 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	848	53	2,248	1.00
2.00	HMO and other (see instructions)			456	411		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	848	53	2,248	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 7/30/2021 9:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	50,486,566	0	50,486,566	1,287,987.00	39.20	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		15,000	0	15,000	180.00	83.33	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		5,153,748	0	5,153,748	37,947.00	135.81	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		11,947,935	0	11,947,935	291,603.00	40.97	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)		3,014,134	419,628	3,433,762	97,890.00	35.08	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,937,517	0	1,937,517	33,537.00	57.77	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		171,000	0	171,000	1,416.00	120.76	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,799,038	0	10,799,038			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		561,172	0	561,172			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		2,877	0	2,877			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		717,363	0	717,363			23.00
24.00	Wage-related costs (RHC/FQHC)		3,501,046	0	3,501,046			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 7/30/2021 9:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	284,954	0	284,954	8,312.00	34.28	26.00
27.00	Administrative & General	5.00	6,641,642	0	6,641,642	144,489.00	45.97	27.00
28.00	Administrative & General under contract (see inst.)		511,814	0	511,814	2,628.00	194.75	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,495,248	0	1,495,248	51,002.00	29.32	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	572,744	-25,033	547,711	37,546.00	14.59	32.00
33.00	Housekeeping under contract (see instructions)		93,510	0	93,510	1,930.00	48.45	33.00
34.00	Dietary	10.00	816,113	-512,210	303,903	15,261.00	19.91	34.00
35.00	Dietary under contract (see instructions)		3,165	0	3,165	32.00	98.91	35.00
36.00	Cafeteria	11.00	0	291,470	291,470	14,642.00	19.91	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,214,220	25,000	2,239,220	47,689.00	46.95	38.00
39.00	Central Services and Supply	14.00	568,369	0	568,369	15,244.00	37.28	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	703,060	0	703,060	29,449.00	23.87	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 7/30/2021 9:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		33,993,372	0	33,993,372	963,027.00	35.30	1.00
2.00	Excluded area salaries (see instructions)		3,014,134	419,628	3,433,762	97,890.00	35.08	2.00
3.00	Subtotal salaries (line 1 minus line 2)		30,979,238	-419,628	30,559,610	865,137.00	35.32	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,108,517	0	2,108,517	34,953.00	60.32	4.00
5.00	Subtotal wage-related costs (see inst.)		10,801,915	0	10,801,915	0.00	35.35	5.00
6.00	Total (sum of lines 3 thru 5)		43,889,670	-419,628	43,470,042	900,090.00	48.30	6.00
7.00	Total overhead cost (see instructions)		13,904,839	-220,773	13,684,066	368,224.00	37.16	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 7/30/2021 9:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,132,754	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,862,924	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	104,124	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	202,556	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)	617,804	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	321,682	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	3,277,023	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	42,629	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	20,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,581,496	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 7/30/2021 9:15 am

	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	1,148,742	15,581,496	1.00
2.00	Hospital	1,148,742	15,581,496	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-4 | Date/Time Prepared: 7/30/2021 9:15 am

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	250.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			2.77	0.00	2.77	4.00
5.00	Other Administrative Personnel			3.96	0.00	3.96	5.00
6.00	Direct Nursing Service			43.21	0.00	43.21	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			29.55	0.00	29.55	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			4.60	0.00	4.60	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.44	0.00	0.44	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			6.21	0.00	6.21	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			20.00
20.01				26900			20.01
20.02				34620			20.02
20.03				99915			20.03
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,346	189	32	11	1,578	21.00
22.00	Skilled Nursing Visit Charges	441,134	62,141	10,503	3,729	517,507	22.00
23.00	Physical Therapy Visits	1,699	237	7	6	1,949	23.00
24.00	Physical Therapy Visit Charges	563,401	78,551	2,357	2,034	646,343	24.00
25.00	Occupational Therapy Visits	172	157	0	0	329	25.00
26.00	Occupational Therapy Visit Charges	55,015	50,779	0	0	105,794	26.00
27.00	Speech Pathology Visits	5	65	0	0	70	27.00
28.00	Speech Pathology Visit Charges	1,679	21,443	0	0	23,122	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	340	207	0	0	547	31.00
32.00	Home Health Aide Visit Charges	53,304	32,213	0	0	85,517	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,562	855	39	17	4,473	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,114,533	245,127	12,860	5,763	1,378,283	35.00
36.00	Total Number of Episodes (standard/non outlier)	315		23	2	340	36.00
37.00	Total Number of Outlier Episodes		29		0	29	37.00
38.00	Total Non-Routine Medical Supply Charges	1,085	66	46	0	1,197	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/30/2021 9:15 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	2200 FOREST RIDGE PARKWAY	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE	IN	47362	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2020 To 12/31/2020	Worksheet S-8 Date/Time Prepared: 7/30/2021 9:15 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/30/2021 9:15 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			152 WITTENBRAKER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE		IN	47362	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	19:00	07:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	07:30	19:00	07:30	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0030
Component CCN: 15-8525

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

Worksheet S-8
Date/Time Prepared:
7/30/2021 9:15 am

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/30/2021 9:15 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			415 E. MAIN ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CAMBRIDGE CITY		IN	47327	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	19:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/30/2021 9:15 am

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,497	0	1,028	4,525	11.00
12.00	Hospice Inpatient Respite Care	24	0	0	24	12.00
13.00	Hospice General Inpatient Care	21	0	0	21	13.00
14.00	Total Hospice Days	3,542	0	1,028	4,570	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/30/2021 9:15 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.322873	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,803,068	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	42,451,139	6.00
7.00	Medicaid cost (line 1 times line 6)	13,706,327	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)	7,903,259	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)	7,903,259	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)	672,484	522,065	1,194,549	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	217,127	522,065	739,192	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)	217,127	522,065	739,192	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)	6,570,196	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	159,957	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	246,087	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,324,109	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,128,014	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,867,206	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,770,465	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,353,429	5,353,429	-92,605	5,260,824	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	341,695	341,695	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	284,954	10,895,343	11,180,297	2,327,451	13,507,748	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,641,642	9,490,759	16,132,401	-2,500	16,129,901	5.00
7.00	00700	OPERATION OF PLANT	1,495,248	1,697,067	3,192,315	0	3,192,315	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	444,824	444,824	0	444,824	8.00
9.00	00900	HOUSEKEEPING	572,744	347,061	919,805	-40,202	879,603	9.00
10.00	01000	DIETARY	816,113	511,684	1,327,797	-828,715	499,082	10.00
11.00	01100	CAFETERIA	0	0	0	474,215	474,215	11.00
13.00	01300	NURSING ADMINISTRATION	2,214,220	216,103	2,430,323	24,281	2,454,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	568,369	448,672	1,017,041	0	1,017,041	14.00
15.00	01500	PHARMACY	0	5,203,351	5,203,351	-197,510	5,005,841	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	703,060	163,181	866,241	-694	865,547	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,105,420	2,138,692	8,244,112	-820,755	7,423,357	30.00
31.00	03100	INTENSIVE CARE UNIT	1,431,380	354,813	1,786,193	0	1,786,193	31.00
43.00	04300	NURSERY	0	0	0	592,978	592,978	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,027,388	9,882,736	14,910,124	-8,328,779	6,581,345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	215,339	215,339	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,760,606	930,932	2,691,538	-283,577	2,407,961	54.00
57.00	05700	CT SCAN	184,384	867,494	1,051,878	0	1,051,878	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	106,119	499,000	605,119	-22,000	583,119	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,965,601	3,172,119	5,137,720	0	5,137,720	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	811,310	304,024	1,115,334	-1,682	1,113,652	65.00
66.00	06600	PHYSICAL THERAPY	1,546,663	968,799	2,515,462	-558	2,514,904	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,058	16,264	238,322	0	238,322	67.00
68.00	06800	SPEECH PATHOLOGY	88,753	6,214	94,967	0	94,967	68.00
69.00	06900	ELECTROCARDIOLOGY	176,849	178,095	354,944	0	354,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-417,967	-417,967	2,558,145	2,140,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,480,052	5,480,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	110,362	12,802	123,164	0	123,164	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,084,724	1,832,587	5,917,311	-779,600	5,137,711	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,570,783	3,618,075	11,188,858	-940,034	10,248,824	88.01
88.02	08802	RURAL HEALTH CLINIC III	501,305	403,110	904,415	-349,889	554,526	88.02
91.00	09100	EMERGENCY	2,482,377	1,077,420	3,559,797	0	3,559,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,153,854	262,398	1,416,252	-13,221	1,403,031	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	513,525	452,582	966,107	-6,026	960,081	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,139,811	61,331,663	110,471,474	-694,191	109,777,283	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	1,165,908	602,101	1,768,009	-85,748	1,682,261	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	92,605	92,605	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	206,569	206,569	0	206,569	194.05
194.06	07956	DR AFZAL	0	4,402	4,402	0	4,402	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	394,702	394,702	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	294,632	294,632	194.10
194.11	07961	WELL BEING	0	568	568	0	568	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	64,502	64,502	0	64,502	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	180,847	1,441,323	1,622,170	-2,000	1,620,170	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	50,486,566	63,651,128	114,137,694	0	114,137,694	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-127,760	5,133,064		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	341,695		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,796,257	16,304,005		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,100,207	14,029,694		5.00
7.00	00700	OPERATION OF PLANT	0	3,192,315		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	444,824		8.00
9.00	00900	HOUSEKEEPING	6,265	885,868		9.00
10.00	01000	DIETARY	-48,313	450,769		10.00
11.00	01100	CAFETERIA	-254,516	219,699		11.00
13.00	01300	NURSING ADMINISTRATION	89,978	2,544,582		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,017,041		14.00
15.00	01500	PHARMACY	-875,677	4,130,164		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,429	859,118		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,080,397	4,342,960		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,786,193		31.00
43.00	04300	NURSERY	0	592,978		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,946,434	3,634,911		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	215,339		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,043	2,406,918		54.00
57.00	05700	CT SCAN	-553,509	498,369		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-294,022	289,097		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-30,162	5,107,558		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-1,630	1,112,022		65.00
66.00	06600	PHYSICAL THERAPY	-678,916	1,835,988		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	238,322		67.00
68.00	06800	SPEECH PATHOLOGY	0	94,967		68.00
69.00	06900	ELECTROCARDIOLOGY	0	354,944		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,140,178		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,480,052		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	350	123,514		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-446,097	4,691,614		88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,305,362	7,943,462		88.01
88.02	08802	RURAL HEALTH CLINIC III	-120,917	433,609		88.02
91.00	09100	EMERGENCY	-46,534	3,513,263		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-16,268	1,386,763		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	-15,673	944,408		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,057,016	98,720,267		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-45,822	1,636,439		192.00
194.00	07950	HOSPITALIST	0	0		194.00
194.01	07951	RENTAL	0	92,605		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	206,569		194.05
194.06	07956	DR AFZAL	0	4,402		194.06
194.07	07957	PHILLIPS HALL	0	0		194.07
194.08	07958	OB DRS	0	0		194.08
194.09	07959	THE WATERS	0	394,702		194.09
194.10	07960	CAMBRIDGE CITY	0	294,632		194.10
194.11	07961	WELL BEING	0	568		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	64,502		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	1,620,170		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,102,838	103,034,856		200.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/30/2021 9:15 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB/NURSERY/L&D				
1.00	NURSERY	43.00	522,538	70,440	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	189,759	25,580	2.00
	0		712,297	96,020	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	291,470	182,745	1.00
	0		291,470	182,745	
	C - WATERS EXCLUSIONS				
1.00	THE WATERS	194.09	245,773	148,929	1.00
2.00		0.00	0	0	2.00
	0		245,773	148,929	
	D - DEPRECIATION POB				
1.00	RENTAL	194.01	0	92,605	1.00
	0		0	92,605	
	E - EQUIPMENT RENTAL				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	341,695	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
	0		0	341,695	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	5,480,052	1.00
	0		0	5,480,052	
	I - MEDICAL DIRECTOR RECLASS				
1.00	NURSING ADMINISTRATION	13.00	25,000	0	1.00
	0		25,000	0	
	L - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,038,197	1.00
	0		0	8,038,197	
	M - FOREST RIDGE STAFF RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	10,022	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	96,423	0	2.00
	0		106,445	0	
	O - BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,327,451	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
	0		0	2,327,451	
	P - CAMBRIDGE CITY RECLASS				
1.00	CAMBRIDGE CITY	194.10	208,877	85,755	1.00
	TOTALS		208,877	85,755	
500.00	Grand Total: Increases		1,589,862	16,793,449	500.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/30/2021 9:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB/NURSERY/L&D						
1.00	ADULTS & PEDIATRICS	30.00	712,297	96,020	0		1.00
2.00		0.00	0	0	0		2.00
	0		712,297	96,020			
	B - CAFETERIA						
1.00	DIETARY	10.00	291,470	182,745	0		1.00
	0		291,470	182,745			
	C - WATERS EXCLUSIONS						
1.00	HOUSEKEEPING	9.00	25,033	15,169	0		1.00
2.00	DIETARY	10.00	220,740	133,760	0		2.00
	0		245,773	148,929			
	D - DEPRECIATION POB						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	92,605	9		1.00
	0		0	92,605			
	E - EQUIPMENT RENTAL						
1.00	NURSING ADMINISTRATION	13.00	0	719	9		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	694	0		2.00
3.00	OPERATING ROOM	50.00	0	32,465	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	283,577	0		4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	22,000	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,682	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	558	0		7.00
	0		0	341,695			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,480,052	0		1.00
	0		0	5,480,052			
	I - MEDICAL DIRECTOR RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,000	0	0		1.00
	0		25,000	0			
	L - MED SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	8,038,197	0		1.00
	0		0	8,038,197			
	M - FOREST RIDGE STAFF RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	96,423	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	10,022	0	0		2.00
	0		106,445	0			
	O - BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,500	0		1.00
2.00	PHARMACY	15.00	0	197,510	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	12,438	0		3.00
4.00	OPERATING ROOM	50.00	0	258,117	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	693,199	0		5.00
6.00	RURAL HEALTH CLINIC II	88.01	0	1,036,457	0		6.00
7.00	RURAL HEALTH CLINIC III	88.02		55,257	0		7.00
8.00	HOME HEALTH AGENCY	101.00	0	13,221	0		8.00
9.00	HOSPICE	116.00	0	6,026	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	50,726	0		10.00
11.00	HENRY COUNTY RADIOLOGY	194.14	0	2,000	0		11.00
	0		0	2,327,451			
	P - CAMBRIDGE CITY RECLASS						
1.00	RURAL HEALTH CLINIC III	88.02	208,877	85,755	0		1.00
	TOTALS		208,877	85,755			
500.00	Grand Total: Decreases		1,589,862	16,793,449			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/30/2021 9:15 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0	0	0	0	1.00
2.00	Land Improvements	2,117,571	0	0	0	5,000	2.00
3.00	Buildings and Fixtures	41,619,768	577,574	0	577,574	115,058	3.00
4.00	Building Improvements	1,115,708	782,514	0	782,514	0	4.00
5.00	Fixed Equipment	18,029,130	4,887,362	0	4,887,362	156,853	5.00
6.00	Movable Equipment	37,295,443	7,725,672	0	7,725,672	6,759,743	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	100,223,620	13,973,122	0	13,973,122	7,036,654	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	100,223,620	13,973,122	0	13,973,122	7,036,654	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	46,000	0	1.00
2.00	Land Improvements	2,112,571	0	2.00
3.00	Buildings and Fixtures	42,082,284	0	3.00
4.00	Building Improvements	1,898,222	0	4.00
5.00	Fixed Equipment	22,759,639	0	5.00
6.00	Movable Equipment	38,261,372	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	107,160,088	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	107,160,088	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 7/30/2021 9:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,119,704	0	233,725	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,119,704	0	233,725	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,353,429		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	5,353,429		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/30/2021 9:15 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	68,898,716	0	68,898,716	0.642951	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	38,261,372	0	38,261,372	0.357049	0	2.00
3.00	Total (sum of lines 1-2)	107,160,088	0	107,160,088	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,027,099	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	341,695	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,368,794	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	105,965	0	0	0	5,133,064	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	341,695	2.00
3.00	Total (sum of lines 1-2)	105,965	0	0	0	5,474,759	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/30/2021 9:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-127,760	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4,882	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-28,480	ADMINISTRATIVE & GENERAL	5.00	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	-7,292,888			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	-2,610,770			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-254,516	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,429	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/30/2021 9:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OP REV - HUMAN RESOURSEC - MIS	B	-178	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	OTHER OP REV - PHY REAPP FEES	B	-35,908	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER OP REV	B	6,287	HOUSEKEEPING	9.00	0	33.02
33.03	DIETARY-OTHER OP REV	B	-48,313	DIETARY	10.00	0	33.03
33.04	OTHER OP REV - PHARMACY	B	-884,200	PHARMACY	15.00	0	33.04
33.05	OTHER OP REV - HEALTH PROGRAM	B	-68	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	OTHER OP REV - MEDICAL RECORDS	B	-1,526	OPERATING ROOM	50.00	0	33.06
33.07	OTHER OP REV - LABORATORY-LAB DRUG S	B	-1,330	LABORATORY	60.00	0	33.07
33.08	OTHER OP REV - AQUATICS - HLTH PROG	B	-100,241	PHYSICAL THERAPY	66.00	0	33.08
33.09	OTHER INCOME	B	350	CARDIAC REHAB	76.00	0	33.09
33.10	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-892	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	OTHER OP REV - NORTHFIELD PARK	B	-263,764	RURAL HEALTH CLINIC II	88.01	0	33.11
33.12	PUBLIC RELATIONS	A	-16,042	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	PUBLIC RELATIONS	A	-122,271	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	PUBLIC RELATIONS	A	-22	HOUSEKEEPING	9.00	0	33.14
33.15	PUBLIC RELATIONS	A	-22	NURSING ADMINISTRATION	13.00	0	33.15
33.16	PUBLIC RELATIONS	A	-248	ADULTS & PEDIATRICS	30.00	0	33.16
33.17	PUBLIC RELATIONS	A	-1,043	RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.18	PUBLIC RELATIONS	A	-150	PHYSICAL THERAPY	66.00	0	33.18
33.19	PUBLIC RELATIONS	A	-59,473	RURAL HEALTH CLINIC	88.00	0	33.19
33.20	PUBLIC RELATIONS	A	-42,307	RURAL HEALTH CLINIC II	88.01	0	33.20
33.21	PUBLIC RELATIONS	A	-30,429	RURAL HEALTH CLINIC III	88.02	0	33.21
33.22	PUBLIC RELATIONS	A	-5,976	EMERGENCY	91.00	0	33.22
33.23	PUBLIC RELATIONS	A	-1,392	HOME HEALTH AGENCY	101.00	0	33.23
33.24	PUBLIC RELATIONS	A	-794	HOSPICE	116.00	0	33.24
33.25	AHA & IHA DUES	A	-8,579	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	BENEFIT EXPENSE	A	2,812,477	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-111,800	RURAL HEALTH CLINIC	88.00	0	33.27
33.28	MEDICAL DIRECTOR	A	90,000	NURSING ADMINISTRATION	13.00	0	33.28
33.29	HAF EXPENSE	A	-1,858,057	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	PHYSICIAN RECRUITMENT	A	-27,235	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	PHYSICIAN RECRUITMENT	A	-15,000	ADULTS & PEDIATRICS	30.00	0	33.31
33.32	PHYSICIAN RECRUITMENT	A	-41,467	OPERATING ROOM	50.00	0	33.32
33.33	PHYSICIAN RECRUITMENT	A	-7,500	EMERGENCY	91.00	0	33.33
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,102,838				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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/30/2021 9:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	RENT EXPENSE	0	14,795	1.00
2.00	15.00	PHARMACY	RENT EXPENSE	9,016	493	2.00
3.00	57.00	CT SCAN	RENT EXPENSE	208,771	762,280	3.00
3.01	58.00	MAGNETIC RESONANCE IMAGING (	RENT EXPENSE	155,978	450,000	3.01
3.02	60.00	LABORATORY	RENT EXPENSE	5,376	34,208	3.02
4.00	65.00	RESPIRATORY THERAPY	RENT EXPENSE	21,826	23,456	4.00
4.01	66.00	PHYSICAL THERAPY	RENT EXPENSE	162,399	740,924	4.01
4.02	88.00	RURAL HEALTH CLINIC	RENT EXPENSE	217,923	491,855	4.02
4.03	88.01	RURAL HEALTH CLINIC II	RENT EXPENSE	537,027	1,245,010	4.03
4.04	88.02	RURAL HEALTH CLINIC III	RENT EXPENSE	51,553	142,041	4.04
4.05	101.00	HOME HEALTH AGENCY	RENT EXPENSE	7,605	22,481	4.05
4.06	116.00	HOSPICE	RENT EXPENSE	7,601	22,480	4.06
4.07	192.00	PHYSICIANS' PRIVATE OFFICES	RENT EXPENSE	2,928	48,750	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,388,003	3,998,773	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	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDA	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC				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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/30/2021 9:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-14,795	0		1.00
2.00	8,523	0		2.00
3.00	-553,509	0		3.00
3.01	-294,022	0		3.01
3.02	-28,832	0		3.02
4.00	-1,630	0		4.00
4.01	-578,525	0		4.01
4.02	-273,932	0		4.02
4.03	-707,983	0		4.03
4.04	-90,488	0		4.04
4.05	-14,876	0		4.05
4.06	-14,879	0		4.06
4.07	-45,822	0		4.07
5.00	-2,610,770			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	MISC		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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/30/2021 9:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	25,000	0	25,000	211,500	260	1.00
2.00	30.00	ADULTS & PEDIATRICS	3,065,081	3,065,081	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	2,921,952	2,903,441	18,511	246,400	180	3.00
4.00	60.00	LABORATORY	56,000	0	56,000	211,500	596	4.00
5.00	88.01	RURAL HEALTH CLINIC II	1,291,308	1,291,308	0	211,500	0	5.00
6.00	91.00	EMERGENCY	90,000	0	90,000	211,500	560	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,449,341	7,259,830	189,511		1,596	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	13.00	NURSING ADMINISTRATION	26,438	1,322	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	21,323	1,066	0	0	0	3.00
4.00	60.00	LABORATORY	60,603	3,030	0	0	0	4.00
5.00	88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	56,942	2,847	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			165,306	8,265	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	13.00	NURSING ADMINISTRATION	0	26,438	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,065,081		2.00
3.00	50.00	OPERATING ROOM	0	21,323	0	2,903,441		3.00
4.00	60.00	LABORATORY	0	60,603	0	0		4.00
5.00	88.01	RURAL HEALTH CLINIC II	0	0	0	1,291,308		5.00
6.00	91.00	EMERGENCY	0	56,942	33,058	33,058		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	165,306	33,058	7,292,888		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,133,064	5,133,064				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	341,695		341,695			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,304,005	33,790	2,131	16,339,926		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,029,694	701,696	44,257	2,161,761	16,937,408	5.00
7.00	00700	OPERATION OF PLANT	3,192,315	1,332,618	84,051	486,682	5,095,666	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	444,824	66,588	4,200	0	515,612	8.00
9.00	00900	HOUSEKEEPING	885,868	38,676	2,439	178,272	1,105,255	9.00
10.00	01000	DIETARY	450,769	140,495	8,861	98,916	699,041	10.00
11.00	01100	CAFETERIA	219,699	38,384	2,421	94,869	355,373	11.00
13.00	01300	NURSING ADMINISTRATION	2,544,582	77,157	4,866	728,835	3,355,440	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,017,041	139,230	8,781	184,996	1,350,048	14.00
15.00	01500	PHARMACY	4,130,164	30,404	1,918	0	4,162,486	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	859,118	45,021	2,840	228,836	1,135,815	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,342,960	571,381	36,038	1,755,386	6,705,765	30.00
31.00	03100	INTENSIVE CARE UNIT	1,786,193	225,808	14,242	465,894	2,492,137	31.00
43.00	04300	NURSERY	592,978	59,717	3,766	170,079	826,540	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,634,911	415,976	26,236	1,636,344	5,713,467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,339	30,345	1,914	61,764	309,362	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,406,918	220,377	13,900	573,053	3,214,248	54.00
57.00	05700	CT SCAN	498,369	8,525	538	60,014	567,446	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,097	10,414	657	34,540	334,708	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,107,558	160,796	10,142	639,776	5,918,272	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,112,022	40,934	2,582	264,070	1,419,608	65.00
66.00	06600	PHYSICAL THERAPY	1,835,988	20,379	1,285	503,417	2,361,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	238,322	3,893	246	72,277	314,738	67.00
68.00	06800	SPEECH PATHOLOGY	94,967	3,757	237	28,888	127,849	68.00
69.00	06900	ELECTROCARDIOLOGY	354,944	0	0	57,562	412,506	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,140,178	0	0	0	2,140,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,480,052	0	0	0	5,480,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	123,514	13,839	873	35,921	174,147	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,691,614	0	0	1,301,398	5,993,012	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,943,462	0	0	2,495,574	10,439,036	88.01
88.02	08802	RURAL HEALTH CLINIC III	433,609	0	0	95,181	528,790	88.02
91.00	09100	EMERGENCY	3,513,263	205,701	12,974	807,979	4,539,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,386,763	0	0	375,563	1,762,326	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	944,408	0	0	167,145	1,111,553	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,720,267	4,635,901	292,395	15,764,992	97,598,870	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,640	1,239	0	20,879	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,636,439	0	0	368,088	2,004,527	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	92,605	0	17,943	0	110,548	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	206,569	0	0	0	206,569	194.05
194.06	07956	DR AFZAL	4,402	0	0	0	4,402	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	394,702	477,523	30,118	79,996	982,339	194.09
194.10	07960	CAMBRIDGE CITY	294,632	0	0	67,987	362,619	194.10
194.11	07961	WELL BEING	568	0	0	0	568	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	64,502	0	0	0	64,502	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	1,620,170	0	0	58,863	1,679,033	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	103,034,856	5,133,064	341,695	16,339,926	103,034,856	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,937,408					5.00
7.00	00700	OPERATION OF PLANT	1,002,440	6,098,106				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,433	93,578	710,623			8.00
9.00	00900	HOUSEKEEPING	217,430	54,352	30,154	1,407,191		9.00
10.00	01000	DIETARY	137,518	197,441	8,099	45,805	1,087,904	10.00
11.00	01100	CAFETERIA	69,910	53,942	0	13,983	0	11.00
13.00	01300	NURSING ADMINISTRATION	660,096	108,431	0	7,232	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	265,587	195,663	0	4,822	0	14.00
15.00	01500	PHARMACY	818,861	42,727	0	11,813	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223,442	63,270	0	4,822	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,319,185	802,976	143,533	377,049	897,339	30.00
31.00	03100	INTENSIVE CARE UNIT	490,263	317,334	32,339	92,334	190,565	31.00
43.00	04300	NURSERY	162,600	83,922	10,376	6,750	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,123,976	584,582	127,765	178,882	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,859	42,645	3,747	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,320	309,702	51,711	54,967	0	54.00
57.00	05700	CT SCAN	111,630	11,981	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	65,845	14,634	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,164,266	225,971	899	16,635	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	279,271	79,135	0	34,475	0	65.00
66.00	06600	PHYSICAL THERAPY	464,479	716,291	13,695	107,281	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,917	5,471	1,954	15,188	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,151	5,279	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	81,150	0	0	4,822	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	421,024	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,078,058	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	34,259	19,449	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,178,969	431,263	4,418	43,877	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,053,582	1,114,758	2,130	132,113	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	104,026	81,378	0	0	0	88.02
91.00	09100	EMERGENCY	893,111	289,077	127,298	112,344	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	346,692	62,641	0	9,643	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	218,669	62,613	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,868,019	6,070,506	558,118	1,274,837	1,087,904	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,107	27,600	0	3,134	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	394,339	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	21,747	0	0	120,300	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	40,637	0	13,270	0	0	194.05
194.06	07956	DR AFZAL	866	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	5,771	8,920	0	194.07
194.08	07958	OB DRS	0	0	9,536	0	0	194.08
194.09	07959	THE WATERS	193,250	0	123,928	0	0	194.09
194.10	07960	CAMBRIDGE CITY	71,336	0	0	0	0	194.10
194.11	07961	WELL BEING	112	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	12,689	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	330,306	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	16,937,408	6,098,106	710,623	1,407,191	1,087,904	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/30/2021 9:15 am

		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	493,208					11.00
13.00	01300	NURSING ADMINISTRATION	37,508	4,168,707				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,989	0	1,828,109			14.00
15.00	01500	PHARMACY	0	0	3,353	5,039,240		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,162	0	518	0	1,451,029	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,084	780,306	47,023	0	135,050	30.00
31.00	03100	INTENSIVE CARE UNIT	28,368	240,386	16,140	0	61,166	31.00
43.00	04300	NURSERY	9,046	76,650	4,730	0	46,632	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,490	648,153	109,732	0	250,112	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,285	27,838	1,718	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,037	0	25,342	0	176,231	54.00
57.00	05700	CT SCAN	3,562	0	14,676	0	79,940	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,479	0	2,727	0	21,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	52,644	0	230,279	0	248,904	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	17,022	0	5,231	0	14,535	65.00
66.00	06600	PHYSICAL THERAPY	36,411	0	5,225	0	9,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,155	0	0	0	1,817	67.00
68.00	06800	SPEECH PATHOLOGY	1,439	0	0	0	606	68.00
69.00	06900	ELECTROCARDIOLOGY	3,310	0	7,795	0	15,746	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	352,974	0	46,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	906,123	0	61,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,039,240	0	73.00
76.00	03950	CARDIAC REHAB	2,942	24,926	536	0	2,422	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	726,509	7,820	0	10,295	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,154,410	13,831	0	35,731	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	63,514	2,135	0	0	88.02
91.00	09100	EMERGENCY	50,275	426,015	64,542	0	221,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	3,602	0	7,267	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	2,057	0	4,239	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493,208	4,168,707	1,828,109	5,039,240	1,451,029	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	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	493,208	4,168,707	1,828,109	5,039,240	1,451,029	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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	11,300,310	0	11,300,310		30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,032	0	3,961,032		31.00
43.00	04300	NURSERY	1,227,246	0	1,227,246		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,813,159	0	8,813,159		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	449,454	0	449,454		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,558	0	4,501,558		54.00
57.00	05700	CT SCAN	789,235	0	789,235		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	441,589	0	441,589		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	7,857,870	0	7,857,870		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	1,849,277	0	1,849,277		65.00
66.00	06600	PHYSICAL THERAPY	3,714,141	0	3,714,141		66.00
67.00	06700	OCCUPATIONAL THERAPY	405,240	0	405,240		67.00
68.00	06800	SPEECH PATHOLOGY	160,324	0	160,324		68.00
69.00	06900	ELECTROCARDIOLOGY	525,329	0	525,329		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,960,808	0	2,960,808		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,526,005	0	7,526,005		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,039,240	0	5,039,240		73.00
76.00	03950	CARDIAC REHAB	258,681	0	258,681		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,396,163	0	8,396,163		88.00
88.01	08801	RURAL HEALTH CLINIC II	14,945,591	0	14,945,591		88.01
88.02	08802	RURAL HEALTH CLINIC III	779,843	0	779,843		88.02
91.00	09100	EMERGENCY	6,723,625	0	6,723,625		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	2,192,171	0	2,192,171		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,399,131	0	1,399,131		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,217,022	0	96,217,022		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,720	0	55,720		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,398,866	0	2,398,866		192.00
194.00	07950	HOSPITALIST	0	0	0		194.00
194.01	07951	RENTAL	252,595	0	252,595		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	260,476	0	260,476		194.05
194.06	07956	DR AFZAL	5,268	0	5,268		194.06
194.07	07957	PHILLIPS HALL	14,691	0	14,691		194.07
194.08	07958	OB DRS	9,536	0	9,536		194.08
194.09	07959	THE WATERS	1,299,517	0	1,299,517		194.09
194.10	07960	CAMBRIDGE CITY	433,955	0	433,955		194.10
194.11	07961	WELL BEING	680	0	680		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	77,191	0	77,191		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	2,009,339	0	2,009,339		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194.16
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)	103,034,856	0	103,034,856		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,790	2,131	35,921	35,921	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	701,696	44,257	745,953	4,755	5.00
7.00	00700	OPERATION OF PLANT	0	1,332,618	84,051	1,416,669	1,071	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,588	4,200	70,788	0	8.00
9.00	00900	HOUSEKEEPING	0	38,676	2,439	41,115	392	9.00
10.00	01000	DIETARY	0	140,495	8,861	149,356	218	10.00
11.00	01100	CAFETERIA	0	38,384	2,421	40,805	209	11.00
13.00	01300	NURSING ADMINISTRATION	0	77,157	4,866	82,023	1,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	139,230	8,781	148,011	407	14.00
15.00	01500	PHARMACY	0	30,404	1,918	32,322	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,021	2,840	47,861	503	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	571,381	36,038	607,419	3,861	30.00
31.00	03100	INTENSIVE CARE UNIT	0	225,808	14,242	240,050	1,025	31.00
43.00	04300	NURSERY	0	59,717	3,766	63,483	374	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	415,976	26,236	442,212	3,600	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,345	1,914	32,259	136	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	220,377	13,900	234,277	1,261	54.00
57.00	05700	CT SCAN	0	8,525	538	9,063	132	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,414	657	11,071	76	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	160,796	10,142	170,938	1,407	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	40,934	2,582	43,516	581	65.00
66.00	06600	PHYSICAL THERAPY	0	20,379	1,285	21,664	1,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,893	246	4,139	159	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,757	237	3,994	64	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	127	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	13,839	873	14,712	79	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,863	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	5,466	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	209	88.02
91.00	09100	EMERGENCY	0	205,701	12,974	218,675	1,777	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	826	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	368	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,635,901	292,395	4,928,296	34,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,640	1,239	20,879	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	810	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	17,943	17,943	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	477,523	30,118	507,641	176	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	150	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	129	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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	5,133,064	341,695	5,474,759	35,921	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	750,708					5.00
7.00	00700	OPERATION OF PLANT	44,429	1,462,169				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,496	22,438	97,722			8.00
9.00	00900	HOUSEKEEPING	9,637	13,032	4,147	68,323		9.00
10.00	01000	DIETARY	6,095	47,341	1,114	2,224	206,348	10.00
11.00	01100	CAFETERIA	3,098	12,934	0	679	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,256	25,999	0	351	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,771	46,915	0	234	0	14.00
15.00	01500	PHARMACY	36,293	10,245	0	574	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,903	15,170	0	234	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,468	192,533	19,737	18,307	170,203	30.00
31.00	03100	INTENSIVE CARE UNIT	21,729	76,088	4,447	4,483	36,145	31.00
43.00	04300	NURSERY	7,207	20,122	1,427	328	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,816	140,168	17,570	8,685	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,697	10,225	515	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,025	74,259	7,111	2,669	0	54.00
57.00	05700	CT SCAN	4,948	2,873	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,918	3,509	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	51,601	54,182	124	808	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	12,378	18,975	0	1,674	0	65.00
66.00	06600	PHYSICAL THERAPY	20,586	171,748	1,883	5,209	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,744	1,312	269	737	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,115	1,266	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,597	0	0	234	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,660	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	47,781	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1,518	4,663	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,253	103,406	608	2,130	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	91,041	267,290	293	6,414	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,611	19,512	0	0	0	88.02
91.00	09100	EMERGENCY	39,584	69,313	17,505	5,455	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,366	15,020	0	468	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	9,692	15,013	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	703,313	1,455,551	76,750	61,897	206,348	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	182	6,618	0	152	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,477	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	964	0	0	5,841	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	1,801	0	1,825	0	0	194.05
194.06	07956	DR AFZAL	38	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	794	433	0	194.07
194.08	07958	OB DRS	0	0	1,311	0	0	194.08
194.09	07959	THE WATERS	8,565	0	17,042	0	0	194.09
194.10	07960	CAMBRIDGE CITY	3,162	0	0	0	0	194.10
194.11	07961	WELL BEING	5	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	562	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	14,639	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	750,708	1,462,169	97,722	68,323	206,348	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/30/2021 9:15 am

		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	57,725					11.00
13.00	01300	NURSING ADMINISTRATION	4,390	143,622				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,403	0	208,741			14.00
15.00	01500	PHARMACY	0	0	383	79,817		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,711	0	59	0	76,441	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,779	26,883	5,369	0	7,115	30.00
31.00	03100	INTENSIVE CARE UNIT	3,320	8,282	1,843	0	3,222	31.00
43.00	04300	NURSERY	1,059	2,641	540	0	2,457	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,952	22,330	12,529	0	13,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	385	959	196	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,335	0	2,894	0	9,284	54.00
57.00	05700	CT SCAN	417	0	1,676	0	4,211	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	290	0	311	0	1,117	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,161	0	26,294	0	13,112	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,992	0	597	0	766	65.00
66.00	06600	PHYSICAL THERAPY	4,262	0	597	0	510	66.00
67.00	06700	OCCUPATIONAL THERAPY	486	0	0	0	96	67.00
68.00	06800	SPEECH PATHOLOGY	168	0	0	0	32	68.00
69.00	06900	ELECTROCARDIOLOGY	387	0	890	0	829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	40,303	0	2,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	103,468	0	3,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	79,817	0	73.00
76.00	03950	CARDIAC REHAB	344	859	61	0	128	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	25,030	893	0	542	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	39,773	1,579	0	1,882	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,188	244	0	0	88.02
91.00	09100	EMERGENCY	5,884	14,677	7,369	0	11,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	411	0	383	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	235	0	223	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,725	143,622	208,741	79,817	76,441	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	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	57,725	143,622	208,741	79,817	76,441	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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	1,120,674	0	1,120,674		30.00
31.00	03100	INTENSIVE CARE UNIT	400,634	0	400,634		31.00
43.00	04300	NURSERY	99,638	0	99,638		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	719,038	0	719,038		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,372	0	47,372		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,115	0	364,115		54.00
57.00	05700	CT SCAN	23,320	0	23,320		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,292	0	19,292		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	324,627	0	324,627		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	80,479	0	80,479		65.00
66.00	06600	PHYSICAL THERAPY	227,566	0	227,566		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,942	0	9,942		67.00
68.00	06800	SPEECH PATHOLOGY	6,639	0	6,639		68.00
69.00	06900	ELECTROCARDIOLOGY	6,064	0	6,064		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,420	0	61,420		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	154,503	0	154,503		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,817	0	79,817		73.00
76.00	03950	CARDIAC REHAB	22,364	0	22,364		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	187,725	0	187,725		88.00
88.01	08801	RURAL HEALTH CLINIC II	413,738	0	413,738		88.01
88.02	08802	RURAL HEALTH CLINIC III	26,764	0	26,764		88.02
91.00	09100	EMERGENCY	391,884	0	391,884		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	32,474	0	32,474		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	25,531	0	25,531		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,845,620	0	4,845,620		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,831	0	27,831		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	18,287		192.00
194.00	07950	HOSPITALIST	0	0	0		194.00
194.01	07951	RENTAL	24,748	0	24,748		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	3,626	0	3,626		194.05
194.06	07956	DR AFZAL	38	0	38		194.06
194.07	07957	PHILLIPS HALL	1,227	0	1,227		194.07
194.08	07958	OB DRS	1,311	0	1,311		194.08
194.09	07959	THE WATERS	533,424	0	533,424		194.09
194.10	07960	CAMBRIDGE CITY	3,312	0	3,312		194.10
194.11	07961	WELL BEING	5	0	5		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	562	0	562		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	14,768	0	14,768		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194.16
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)	5,474,759	0	5,474,759		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	263,714					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		278,330				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,736	1,736	50,201,612			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,050	36,050	6,641,642	-16,937,408	86,097,448	5.00
7.00	00700	OPERATION OF PLANT	68,464	68,464	1,495,248	0	5,095,666	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	3,421	0	0	515,612	8.00
9.00	00900	HOUSEKEEPING	1,987	1,987	547,711	0	1,105,255	9.00
10.00	01000	DIETARY	7,218	7,218	303,903	0	699,041	10.00
11.00	01100	CAFETERIA	1,972	1,972	291,470	0	355,373	11.00
13.00	01300	NURSING ADMINISTRATION	3,964	3,964	2,239,220	0	3,355,440	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	568,369	0	1,350,048	14.00
15.00	01500	PHARMACY	1,562	1,562	0	0	4,162,486	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,313	2,313	703,060	0	1,135,815	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,355	29,355	5,393,123	0	6,705,765	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	11,601	1,431,380	0	2,492,137	31.00
43.00	04300	NURSERY	3,068	3,068	522,538	0	826,540	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,371	21,371	5,027,388	0	5,713,467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	189,759	0	309,362	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	11,322	1,760,606	0	3,214,248	54.00
57.00	05700	CT SCAN	438	438	184,384	0	567,446	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	106,119	0	334,708	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	8,261	1,965,601	0	5,918,272	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,103	2,103	811,310	0	1,419,608	65.00
66.00	06600	PHYSICAL THERAPY	1,047	1,047	1,546,663	0	2,361,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	200	200	222,058	0	314,738	67.00
68.00	06800	SPEECH PATHOLOGY	193	193	88,753	0	127,849	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	176,849	0	412,506	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,140,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,480,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	711	711	110,362	0	174,147	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,998,323	0	5,993,012	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	7,667,206	0	10,439,036	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	292,428	0	528,790	88.02
91.00	09100	EMERGENCY	10,568	10,568	2,482,377	0	4,539,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,153,854	0	1,762,326	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	513,525	0	1,111,553	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	238,172	238,172	48,435,229	-16,937,408	80,661,462	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	1,009	0	0	20,879	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,130,886	0	2,004,527	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	14,616	0	0	110,548	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	206,569	194.05
194.06	07956	DR AFZAL	0	0	0	0	4,402	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	24,533	24,533	245,773	0	982,339	194.09
194.10	07960	CAMBRIDGE CITY	0	0	208,877	0	362,619	194.10
194.11	07961	WELL BEING	0	0	0	0	568	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	64,502	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	180,847	0	1,679,033	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	5,133,064	341,695	16,339,926		16,937,408	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.464511	1.227661	0.325486		0.196724	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			35,921		750,708	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000716		0.008719	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	222,933					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	705,361				8.00
9.00	00900	HOUSEKEEPING	1,987	29,931	5,837			9.00
10.00	01000	DIETARY	7,218	8,039	190	7,941		10.00
11.00	01100	CAFETERIA	1,972	0	58	0	627,090	11.00
13.00	01300	NURSING ADMINISTRATION	3,964	0	30	0	47,689	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	20	0	15,244	14.00
15.00	01500	PHARMACY	1,562	0	49	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,313	0	20	0	29,449	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,355	142,471	1,564	6,550	117,082	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	383	1,391	36,069	31.00
43.00	04300	NURSERY	3,068	10,299	28	0	11,501	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,371	126,819	742	0	97,253	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	3,719	0	0	4,177	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	51,328	228	0	47,091	54.00
57.00	05700	CT SCAN	438	0	0	0	4,529	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	3,152	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	892	69	0	66,934	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,893	0	143	0	21,643	65.00
66.00	06600	PHYSICAL THERAPY	26,186	13,594	445	0	46,295	66.00
67.00	06700	OCCUPATIONAL THERAPY	200	1,940	63	0	5,283	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	1,829	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	20	0	4,208	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	711	0	0	0	3,740	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,766	4,385	182	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	40,753	2,114	548	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,975	0	0	0	0	88.02
91.00	09100	EMERGENCY	10,568	126,355	466	0	63,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,290	0	40	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	2,289	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	221,924	553,986	5,288	7,941	627,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	13	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	499	0	0	194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	13,172	0	0	0	194.05
194.06	07956	DR AFZAL	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	5,728	37	0	0	194.07
194.08	07958	OB DRS	0	9,465	0	0	0	194.08
194.09	07959	THE WATERS	0	123,010	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
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)	6,098,106	710,623	1,407,191	1,087,904	493,208	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.353985	1.007460	241.081206	136.998363	0.786503	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/30/2021 9:15 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,462,169	97,722	68,323	206,348	57,725	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.558782	0.138542	11.705157	25.985140	0.092052	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	625,499					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,056,007				14.00
15.00	01500	PHARMACY	0	20,278	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,132	0	2,396		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,082	284,387	0	223		30.00
31.00	03100	INTENSIVE CARE UNIT	36,069	97,611	0	101		31.00
43.00	04300	NURSERY	11,501	28,607	0	77		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,253	663,632	0	413		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,177	10,389	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,260	0	291		54.00
57.00	05700	CT SCAN	0	88,760	0	132		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,495	0	35		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	1,392,675	0	411		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	31,633	0	24		65.00
66.00	06600	PHYSICAL THERAPY	0	31,597	0	16		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1		68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,141	0	26		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,134,707	0	77		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,480,052	0	102		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03950	CARDIAC REHAB	3,740	3,239	0	4		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	109,010	47,296	0	17		88.00
88.01	08801	RURAL HEALTH CLINIC II	173,215	83,647	0	59		88.01
88.02	08802	RURAL HEALTH CLINIC III	9,530	12,912	0	0		88.02
91.00	09100	EMERGENCY	63,922	390,333	0	365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	21,782	0	12		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	12,442	0	7		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	625,499	11,056,007	100	2,396		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	0	0		192.00
194.00	07950	HOSPITALIST	0	0	0	0		194.00
194.01	07951	RENTAL	0	0	0	0		194.01
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0		194.05
194.06	07956	DR AFZAL	0	0	0	0		194.06
194.07	07957	PHILLIPS HALL	0	0	0	0		194.07
194.08	07958	OB DRS	0	0	0	0		194.08
194.09	07959	THE WATERS	0	0	0	0		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0		194.10
194.11	07961	WELL BEING	0	0	0	0		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0		194.16
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)	4,168,707	1,828,109	5,039,240	1,451,029		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.664610	0.165350	50,392.400000	605.604758		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/30/2021 9:15 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	143,622	208,741	79,817	76,441		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.229612	0.018880	798.170000	31.903589		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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/30/2021 9:15 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,300,310		11,300,310	0	11,300,310	30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,032		3,961,032	0	3,961,032	31.00
43.00	04300	NURSERY	1,227,246		1,227,246	0	1,227,246	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,813,159		8,813,159	0	8,813,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	449,454		449,454	0	449,454	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,558		4,501,558	0	4,501,558	54.00
57.00	05700	CT SCAN	789,235		789,235	0	789,235	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	441,589		441,589	0	441,589	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	7,857,870		7,857,870	0	7,857,870	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,849,277	0	1,849,277	0	1,849,277	65.00
66.00	06600	PHYSICAL THERAPY	3,714,141	0	3,714,141	0	3,714,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	405,240	0	405,240	0	405,240	67.00
68.00	06800	SPEECH PATHOLOGY	160,324	0	160,324	0	160,324	68.00
69.00	06900	ELECTROCARDIOLOGY	525,329		525,329	0	525,329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,960,808		2,960,808	0	2,960,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,526,005		7,526,005	0	7,526,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,039,240		5,039,240	0	5,039,240	73.00
76.00	03950	CARDIAC REHAB	258,681		258,681	0	258,681	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,396,163		8,396,163	0	8,396,163	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,945,591		14,945,591	0	14,945,591	88.01
88.02	08802	RURAL HEALTH CLINIC III	779,843		779,843	0	779,843	88.02
91.00	09100	EMERGENCY	6,723,625		6,723,625	33,058	6,756,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,378,128		1,378,128		1,378,128	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,192,171		2,192,171		2,192,171	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,399,131		1,399,131		1,399,131	116.00
200.00		Subtotal (see instructions)	97,595,150	0	97,595,150	33,058	97,628,208	200.00
201.00		Less Observation Beds	1,378,128		1,378,128		1,378,128	201.00
202.00		Total (see instructions)	96,217,022	0	96,217,022	33,058	96,250,080	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/30/2021 9:15 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,787,695		14,787,695			30.00
31.00	03100	INTENSIVE CARE UNIT	6,003,396		6,003,396			31.00
43.00	04300	NURSERY	2,094,430		2,094,430			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,747,364	25,816,401	34,563,765	0.254983	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,199,627	1,186,304	2,385,931	0.188377	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,850,558	16,594,756	18,445,314	0.244049	0.000000	54.00
57.00	05700	CT SCAN	2,810,847	26,099,550	28,910,397	0.027299	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	505,957	7,361,647	7,867,604	0.056128	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,447,830	32,461,998	41,909,828	0.187495	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,160,294	2,237,493	5,397,787	0.342599	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	742,421	2,935,053	3,677,474	1.009971	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,617	467,769	701,386	0.577770	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	93,197	144,468	237,665	0.674580	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,490,368	4,378,192	5,868,560	0.089516	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,117,959	12,282,405	17,400,364	0.170158	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,061,378	11,174,044	23,235,422	0.323902	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,787,271	5,942,088	11,729,359	0.429626	0.000000	73.00
76.00	03950	CARDIAC REHAB	21,242	905,388	926,630	0.279163	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,757,687	3,757,687			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	13,456,386	13,456,386			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	443,199	443,199			88.02
91.00	09100	EMERGENCY	6,087,953	42,184,311	48,272,264	0.139285	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	362,953	1,404,211	1,767,164	0.779853	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,629,893	2,629,893			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,533,072	1,533,072			116.00
200.00		Subtotal (see instructions)	82,606,357	215,396,315	298,002,672			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	82,606,357	215,396,315	298,002,672			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/30/2021 9:15 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.254983	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.188377	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244049	54.00
57.00	05700	CT SCAN	0.027299	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.187495	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.342599	65.00
66.00	06600	PHYSICAL THERAPY	1.009971	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577770	67.00
68.00	06800	SPEECH PATHOLOGY	0.674580	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.170158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429626	73.00
76.00	03950	CARDIAC REHAB	0.279163	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
91.00	09100	EMERGENCY	0.139970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.779853	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/30/2021 9:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,300,310		11,300,310	0	11,300,310	30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,032		3,961,032	0	3,961,032	31.00
43.00	04300	NURSERY	1,227,246		1,227,246	0	1,227,246	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,813,159		8,813,159	0	8,813,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	449,454		449,454	0	449,454	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,558		4,501,558	0	4,501,558	54.00
57.00	05700	CT SCAN	789,235		789,235	0	789,235	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	441,589		441,589	0	441,589	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	7,857,870		7,857,870	0	7,857,870	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,849,277	0	1,849,277	0	1,849,277	65.00
66.00	06600	PHYSICAL THERAPY	3,714,141	0	3,714,141	0	3,714,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	405,240	0	405,240	0	405,240	67.00
68.00	06800	SPEECH PATHOLOGY	160,324	0	160,324	0	160,324	68.00
69.00	06900	ELECTROCARDIOLOGY	525,329		525,329	0	525,329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,960,808		2,960,808	0	2,960,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,526,005		7,526,005	0	7,526,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,039,240		5,039,240	0	5,039,240	73.00
76.00	03950	CARDIAC REHAB	258,681		258,681	0	258,681	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,396,163		8,396,163	0	8,396,163	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,945,591		14,945,591	0	14,945,591	88.01
88.02	08802	RURAL HEALTH CLINIC III	779,843		779,843	0	779,843	88.02
91.00	09100	EMERGENCY	6,723,625		6,723,625	33,058	6,756,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,378,128		1,378,128		1,378,128	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,192,171		2,192,171		2,192,171	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,399,131		1,399,131		1,399,131	116.00
200.00		Subtotal (see instructions)	97,595,150	0	97,595,150	33,058	97,628,208	200.00
201.00		Less Observation Beds	1,378,128		1,378,128		1,378,128	201.00
202.00		Total (see instructions)	96,217,022	0	96,217,022	33,058	96,250,080	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/30/2021 9:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,787,695		14,787,695			30.00
31.00	03100	INTENSIVE CARE UNIT	6,003,396		6,003,396			31.00
43.00	04300	NURSERY	2,094,430		2,094,430			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,747,364	25,816,401	34,563,765	0.254983	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,199,627	1,186,304	2,385,931	0.188377	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,850,558	16,594,756	18,445,314	0.244049	0.000000	54.00
57.00	05700	CT SCAN	2,810,847	26,099,550	28,910,397	0.027299	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	505,957	7,361,647	7,867,604	0.056128	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,447,830	32,461,998	41,909,828	0.187495	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,160,294	2,237,493	5,397,787	0.342599	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	742,421	2,935,053	3,677,474	1.009971	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,617	467,769	701,386	0.577770	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	93,197	144,468	237,665	0.674580	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,490,368	4,378,192	5,868,560	0.089516	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,117,959	12,282,405	17,400,364	0.170158	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,061,378	11,174,044	23,235,422	0.323902	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,787,271	5,942,088	11,729,359	0.429626	0.000000	73.00
76.00	03950	CARDIAC REHAB	21,242	905,388	926,630	0.279163	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,757,687	3,757,687	2.234397	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	13,456,386	13,456,386	1.110669	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	443,199	443,199	1.759578	0.000000	88.02
91.00	09100	EMERGENCY	6,087,953	42,184,311	48,272,264	0.139285	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	362,953	1,404,211	1,767,164	0.779853	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,629,893	2,629,893			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,533,072	1,533,072			116.00
200.00		Subtotal (see instructions)	82,606,357	215,396,315	298,002,672			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	82,606,357	215,396,315	298,002,672			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/30/2021 9:15 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	CARDIAC REHAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,120,674	0	1,120,674	7,306	153.39	30.00
31.00	INTENSIVE CARE UNIT	400,634		400,634	1,391	288.02	31.00
43.00	NURSERY	99,638		99,638	559	178.24	43.00
200.00	Total (lines 30 through 199)	1,620,946		1,620,946	9,256		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	2,568	393,906	30.00
31.00	INTENSIVE CARE UNIT	623	179,436	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	3,191	573,342	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	719,038	34,563,765	0.020803	3,262,707	67,874	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,372	2,385,931	0.019855	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,115	18,445,314	0.019740	1,007,009	19,878	54.00
57.00	05700	CT SCAN	23,320	28,910,397	0.000807	1,220,394	985	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,292	7,867,604	0.002452	166,416	408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	324,627	41,909,828	0.007746	4,243,209	32,868	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	80,479	5,397,787	0.014910	1,084,653	16,172	65.00
66.00	06600	PHYSICAL THERAPY	227,566	3,677,474	0.061881	380,372	23,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,942	701,386	0.014175	127,951	1,814	67.00
68.00	06800	SPEECH PATHOLOGY	6,639	237,665	0.027934	57,844	1,616	68.00
69.00	06900	ELECTROCARDIOLOGY	6,064	5,868,560	0.001033	886,677	916	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,420	17,400,364	0.003530	2,267,064	8,003	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	154,503	23,235,422	0.006649	5,749,883	38,231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,817	11,729,359	0.006805	3,290,775	22,394	73.00
76.00	03950	CARDIAC REHAB	22,364	926,630	0.024135	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	187,725	3,757,687	0.049958	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	413,738	13,456,386	0.030747	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	26,764	443,199	0.060388	0	0	88.02
91.00	09100	EMERGENCY	391,884	48,272,264	0.008118	2,181,609	17,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	136,672	1,767,164	0.077340	87,156	6,741	92.00
200.00		Total (lines 50 through 199)	3,303,341	270,954,186		26,013,719	259,148	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,306	0.00	2,568	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,391	0.00	623	31.00
43.00	04300	NURSERY		0	559	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,256		3,191	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	34,563,765	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,385,931	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,445,314	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	28,910,397	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,867,604	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	41,909,828	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,397,787	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,677,474	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	701,386	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	237,665	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,868,560	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,400,364	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	23,235,422	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,729,359	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	926,630	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,757,687	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	13,456,386	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	443,199	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	48,272,264	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,767,164	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	270,954,186		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,262,707	0	6,464,759	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	574	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,007,009	0	4,459,974	0	54.00
57.00	05700	CT SCAN	0.000000	1,220,394	0	6,513,068	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	166,416	0	1,829,674	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,243,209	0	2,688,930	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	1,084,653	0	210,394	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	380,372	0	16,583	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	127,951	0	1,608	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	57,844	0	2,050	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	886,677	0	2,146,906	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,267,064	0	1,799,521	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,749,883	0	6,187,183	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,290,775	0	4,564,189	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	191,614	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	2,181,609	0	7,711,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	87,156	0	522,196	0	92.00
200.00		Total (lines 50 through 199)		26,013,719	0	45,310,614	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.254983	6,464,759	0	0	1,648,404	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.188377	574	0	0	108	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244049	4,459,974	0	0	1,088,452	54.00
57.00	05700	CT SCAN	0.027299	6,513,068	0	0	177,800	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056128	1,829,674	0	0	102,696	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.187495	2,688,930	400	0	504,161	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.342599	210,394	0	0	72,081	65.00
66.00	06600	PHYSICAL THERAPY	1.009971	16,583	0	0	16,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577770	1,608	0	0	929	67.00
68.00	06800	SPEECH PATHOLOGY	0.674580	2,050	0	0	1,383	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089516	2,146,906	0	0	192,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.170158	1,799,521	0	0	306,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323902	6,187,183	0	0	2,004,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429626	4,564,189	0	1,318	1,960,894	73.00
76.00	03950	CARDIAC REHAB	0.279163	191,614	0	0	53,492	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.139285	7,711,391	0	0	1,074,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.779853	522,196	0	0	407,236	92.00
200.00		Subtotal (see instructions)		45,310,614	400	1,318	9,610,891	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		45,310,614	400	1,318	9,610,891	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	75	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	566		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
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)	75	566		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	75	566		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,306	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,306	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)	6,415	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)	2,568	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)	11,300,310	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)	11,300,310	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)	11,300,310	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)	1,546.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,971,977	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)	3,971,977	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,961,032	1,391	2,847.61	623	1,774,061	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)	6,899,306	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,645,344	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)	573,342	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	259,148	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	832,490	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,812,854	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)	891	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,546.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,378,128	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,120,674	11,300,310	0.099172	1,378,128	136,672	90.00
91.00	Nursing School cost	0	11,300,310	0.000000	1,378,128	0	91.00
92.00	Allied health cost	0	11,300,310	0.000000	1,378,128	0	92.00
93.00	All other Medical Education	0	11,300,310	0.000000	1,378,128	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 9:15 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,306	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,306	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)	6,415	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)	229	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)	559	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)	11,300,310	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)	11,300,310	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)	11,300,310	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)	1,546.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	354,199	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)	354,199	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/30/2021 9:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,227,246	559	2,195.43	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,961,032	1,391	2,847.61	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)	250,793	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	604,992	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	891	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,546.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,378,128	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/30/2021 9:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,120,674	11,300,310	0.099172	1,378,128	136,672	90.00
91.00	Nursing School cost	0	11,300,310	0.000000	1,378,128	0	91.00
92.00	Allied health cost	0	11,300,310	0.000000	1,378,128	0	92.00
93.00	All other Medical Education	0	11,300,310	0.000000	1,378,128	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,096,936		30.00
31.00	03100	INTENSIVE CARE UNIT		1,937,831		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.254983	3,262,707	831,935	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.188377	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244049	1,007,009	245,760	54.00
57.00	05700	CT SCAN	0.027299	1,220,394	33,316	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056128	166,416	9,341	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.187495	4,243,209	795,580	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.342599	1,084,653	371,601	65.00
66.00	06600	PHYSICAL THERAPY	1.009971	380,372	384,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577770	127,951	73,926	67.00
68.00	06800	SPEECH PATHOLOGY	0.674580	57,844	39,020	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089516	886,677	79,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.170158	2,267,064	385,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323902	5,749,883	1,862,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429626	3,290,775	1,413,803	73.00
76.00	03950	CARDIAC REHAB	0.279163	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.139970	2,181,609	305,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.779853	87,156	67,969	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,013,719	6,899,306	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)		26,013,719		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/30/2021 9:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		224,897		30.00
31.00	03100	INTENSIVE CARE UNIT		110,767		31.00
43.00	04300	NURSERY		241,315		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.254983	244,572	62,362	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.188377	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244049	29,618	7,228	54.00
57.00	05700	CT SCAN	0.027299	51,503	1,406	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056128	13,945	783	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.187495	222,992	41,810	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.342599	63,212	21,656	65.00
66.00	06600	PHYSICAL THERAPY	1.009971	6,849	6,917	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577770	2,396	1,384	67.00
68.00	06800	SPEECH PATHOLOGY	0.674580	989	667	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089516	24,217	2,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.170158	212,562	36,169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.323902	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429626	119,061	51,152	73.00
76.00	03950	CARDIAC REHAB	0.279163	476	133	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.234397	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.110669	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.759578	0	0	88.02
91.00	09100	EMERGENCY	0.139285	121,751	16,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.779853	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,114,143	250,793	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,114,143		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,393,433	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,024,758	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)	33,989	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	5,748	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)	45.45	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)	3.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.66	31.00
32.00	Sum of lines 30 and 31	25.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.36	33.00
34.00	Disproportionate share adjustment (see instructions)	192,131	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	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)	476,271	444,600	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	356,553	112,064	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	468,617		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)	8,118,676		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	9,431,471		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,103,272	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	582,298	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	0	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)	9,685,570	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,685,570	61.00
62.00	Deductibles billed to program beneficiaries	861,300	62.00
63.00	Coinsurance billed to program beneficiaries	2,816	63.00
64.00	Allowable bad debts (see instructions)	50,090	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	32,559	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,858	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,854,013	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)	-1,666	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-13,543	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-11,364	70.93
70.94	HRR adjustment amount (see instructions)	-105,508	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	755,064	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	301,642	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)		9,778,638	71.00
71.01	Sequestration adjustment (see instructions)		64,539	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		9,721,732	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)		-7,633	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		206,938	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)	737,102	247,494	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.9964299598	1.0038973054	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-2,631	965	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9917	0.9700	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-6,118	-7,425	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,393,433	0	5,393,433		5,393,433	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,024,758	0		2,024,758	2,024,758	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	33,989	0	33,989		33,989	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	5,748	0		5,748	5,748	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	0.1036	0.1036	0.1036	0.1036		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	192,131	0	139,690	52,441	192,131	11.00
11.01	Uncompensated care payments	36.00	468,617	0	356,553	112,064	468,617	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	8,118,676	0	5,923,665	2,195,011	8,118,676	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,431,471	0	6,855,041	2,576,430	9,431,471	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,103,272	0	6,622,197	2,481,075	9,103,272	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/30/2021 9:15 am

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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	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	582,298	0	426,502	155,796	582,298	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	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	7,048,699	2,636,871	9,685,570	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	577,163	0	427,083	150,080	577,163	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	5,135	0	-581	5,716	5,135	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	582,298	0	426,502	155,796	582,298	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				0.107121	0.114394		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			755,064		755,064	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				301,642	301,642	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/30/2021 9:15 am

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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	5,393,433	5,393,433		5,393,433	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,024,758		2,024,758	2,024,758	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	33,989	33,989		33,989	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	5,748		5,748	5,748	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	0.1036	0.1036	0.1036		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	192,131	139,690	52,441	192,131	11.00
11.01	Uncompensated care payments	36.00	468,617	356,553	112,064	468,617	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	8,118,676	5,923,665	2,195,011	8,118,676	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,431,471	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,103,272	6,908,261	2,195,011	9,103,272	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	582,298	-150,661	732,959	582,298	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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			6,757,600	2,927,970	9,685,570	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/30/2021 9:15 am

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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	577,163	-150,080	727,243	577,163	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	5,135	-581	5,716	5,135	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	582,298	-150,661	732,959	582,298	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	755,064	755,064		755,064	28.00
29.00	Low volume adjustment on or after October 1	70.97	301,642		301,642	301,642	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-11,364	-19,255	7,891	-11,364	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-1,666	-2,631	965	-1,666	30.01
31.00	HRR adjustment (see instructions)	70.94	-105,508	-44,765	-60,743	-105,508	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-13,543	-6,118	-7,425	-13,543	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.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	641	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,610,891	2.00
3.00	OPPS payments	8,437,738	3.00
4.00	Outlier payment (see instructions)	8,029	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)	641	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,718	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)	1,718	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)	1,718	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,077	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)	641	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)	8,445,767	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	4	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,423,415	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,022,989	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	7,022,989	30.00
31.00	Primary payer payments	1,208	31.00
32.00	Subtotal (line 30 minus line 31)	7,021,781	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)	195,997	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	127,398	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	175,684	36.00
37.00	Subtotal (see instructions)	7,149,179	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-75	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)	7,149,254	40.00
40.01	Sequestration adjustment (see instructions)	47,185	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	7,162,565	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)	-60,496	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/30/2021 9:15 am

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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		9,721,732		6,984,505	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	12/31/2020	178,060	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		178,060	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,721,732		7,162,565	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		7,633		60,496	6.02
7.00	Total Medicare program liability (see instructions)		9,714,099		7,102,069	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: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE 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: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/30/2021 9:15 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	604,992		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)	604,992	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)	604,992	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	576,979		8.00
9.00	Ancillary service charges	1,114,143	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,691,122	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,691,122	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,086,130	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)	604,992	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)	604,992	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)	604,992	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)	604,992	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	604,992	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)	604,992	0	40.00
41.00	Interim payments	711,687	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-106,695	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: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/30/2021 9:15 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	24,070,139	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,139,274	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,158,678	0	0	0	7.00
8.00	Prepaid expenses	1,213,333	0	0	0	8.00
9.00	Other current assets	6,474,558	0	0	0	9.00
10.00	Due from other funds	61,489,581	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	110,545,563	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	2,112,571	0	0	0	13.00
14.00	Accumulated depreciation	-1,584,757	0	0	0	14.00
15.00	Buildings	42,082,284	0	0	0	15.00
16.00	Accumulated depreciation	-32,692,464	0	0	0	16.00
17.00	Leasehold improvements	1,898,222	0	0	0	17.00
18.00	Accumulated depreciation	-1,098,674	0	0	0	18.00
19.00	Fixed equipment	22,759,639	0	0	0	19.00
20.00	Accumulated depreciation	-13,029,351	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	38,261,372	0	0	0	23.00
24.00	Accumulated depreciation	-23,901,050	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)	34,853,792	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	12,900,936	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	7,772,370	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,673,306	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	166,072,661	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,952,330	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,324,114	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,366,037	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	56,137,769	0	0	0	43.00
44.00	Other current liabilities	2,406,976	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	72,187,226	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	12,032,696	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,032,696	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	84,219,922	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	81,852,739				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)	81,852,739	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	166,072,661	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/30/2021 9:15 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		77,124,108		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,728,631				2.00
3.00	Total (sum of line 1 and line 2)		81,852,739		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)		81,852,739		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		81,852,739		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/30/2021 9:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,308,939		11,308,939	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,308,939		11,308,939	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,675,652		5,675,652	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)	5,675,652		5,675,652	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,984,591		16,984,591	17.00
18.00	Ancillary services	52,670,895	158,201,129	210,872,024	18.00
19.00	Outpatient services	6,087,953	42,237,867	48,325,820	19.00
20.00	RURAL HEALTH CLINIC	0	3,757,687	3,757,687	20.00
20.01	RURAL HEALTH CLINIC II	0	13,456,386	13,456,386	20.01
20.02	RURAL HEALTH CLINIC III	0	759,769	759,769	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,629,893	2,629,893	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	0	1,533,072	1,533,072	26.00
27.00	NON-REIMBURSEABLE	3,735	11,456,864	11,460,599	27.00
27.01	PRO FEES	2,693,465	5,640,763	8,334,228	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	78,440,639	239,673,430	318,114,069	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		114,137,694		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)		114,137,694		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/30/2021 9:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	318,114,069	1.00
2.00	Less contractual allowances and discounts on patients' accounts	218,724,532	2.00
3.00	Net patient revenues (line 1 minus line 2)	99,389,537	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	114,137,694	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,748,157	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,456,006	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	5,470,727	24.00
24.01	OTHER NON-OPERATING INCOME	119,759	24.01
24.50	COVID-19 PHE Funding	12,430,296	24.50
25.00	Total other income (sum of lines 6-24)	19,476,788	25.00
26.00	Total (line 5 plus line 25)	4,728,631	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,728,631	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H Date/Time Prepared: 7/30/2021 9:15 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	134,103	0	90,581	0	171,817	396,501	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	548,007	0	0	0	0	548,007	6.00
7.00	Physical Therapy	352,702	0	0	0	0	352,702	7.00
8.00	Occupational Therapy	86,254	0	0	0	0	86,254	8.00
9.00	Speech Pathology	6,424	0	0	0	0	6,424	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,364	0	0	0	0	26,364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,153,854	0	90,581	0	171,817	1,416,252	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-13,221	383,280	-16,268	367,012			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	548,007	0	548,007			6.00
7.00	Physical Therapy	0	352,702	0	352,702			7.00
8.00	Occupational Therapy	0	86,254	0	86,254			8.00
9.00	Speech Pathology	0	6,424	0	6,424			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	26,364	0	26,364			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-13,221	1,403,031	-16,268	1,386,763			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-1 Part I | Date/Time Prepared: 7/30/2021 9:15 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	367,012	0	0	0	0	367,012	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	548,007	0	0	0	0	548,007	6.00
7.00	Physical Therapy	352,702	0	0	0	0	352,702	7.00
8.00	Occupational Therapy	86,254	0	0	0	0	86,254	8.00
9.00	Speech Pathology	6,424	0	0	0	0	6,424	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,364	0	0	0	0	26,364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,386,763	0	0	0	0	1,386,763	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	367,012		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	197,229	745,236	6.00
7.00	Physical Therapy	126,939	479,641	7.00
8.00	Occupational Therapy	31,043	117,297	8.00
9.00	Speech Pathology	2,312	8,736	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	9,489	35,853	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,386,763	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-1 Part II Date/Time Prepared: 7/30/2021 9:15 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-367,012	1,019,751	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	548,007	6.00
7.00	Physical Therapy	0	0	0	0	0	352,702	7.00
8.00	Occupational Therapy	0	0	0	0	0	86,254	8.00
9.00	Speech Pathology	0	0	0	0	0	6,424	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	26,364	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-367,012	1,019,751	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		367,012	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.359904	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-2 Part I
Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	375,563	375,563	73,882	1.00
2.00	Skilled Nursing Care	745,236	0	0	0	745,236	146,606	2.00
3.00	Physical Therapy	479,641	0	0	0	479,641	94,357	3.00
4.00	Occupational Therapy	117,297	0	0	0	117,297	23,075	4.00
5.00	Speech Pathology	8,736	0	0	0	8,736	1,719	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	35,853	0	0	0	35,853	7,053	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,386,763	0	0	375,563	1,762,326	346,692	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	62,641	0	9,643	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	62,641	0	9,643	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030 HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part I Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	3,602	0	7,267	532,598	0	532,598	1.00
2.00	Skilled Nursing Care	0	0	0	891,842	0	891,842	2.00
3.00	Physical Therapy	0	0	0	573,998	0	573,998	3.00
4.00	Occupational Therapy	0	0	0	140,372	0	140,372	4.00
5.00	Speech Pathology	0	0	0	10,455	0	10,455	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	42,906	0	42,906	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,602	0	7,267	2,192,171	0	2,192,171	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	286,214	1,178,056					2.00
3.00	Physical Therapy	184,210	758,208					3.00
4.00	Occupational Therapy	45,049	185,421					4.00
5.00	Speech Pathology	3,355	13,810					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	13,770	56,676					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	532,598	2,192,171					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.320925						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part II | Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	0	1,153,854	0	375,563	2,290	1.00
2.00	Skilled Nursing Care	0	0	0	0	745,236	0	2.00
3.00	Physical Therapy	0	0	0	0	479,641	0	3.00
4.00	Occupational Therapy	0	0	0	0	117,297	0	4.00
5.00	Speech Pathology	0	0	0	0	8,736	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	35,853	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,153,854		1,762,326	2,290	20.00
21.00	Total cost to be allocated	0	0	375,563		346,692	62,641	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.325486		0.196724	27.354148	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	40	0	0	0	21,782	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	40	0	0	0	21,782	20.00
21.00	Total cost to be allocated	0	9,643	0	0	0	3,602	21.00
22.00	Unit cost multiplier	0.000000	241.075000	0.000000	0.000000	0.000000	0.165366	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-2 Part II | Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	12			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	12			20.00
21.00	Total cost to be allocated	0	7,267			21.00
22.00	Unit cost multiplier	0.000000	605.583333			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part I | Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,178,056		1,178,056	5,366	219.54	1.00
2.00	Physical Therapy	3.00	758,208	0	758,208	4,583	165.44	2.00
3.00	Occupational Therapy	4.00	185,421	0	185,421	408	454.46	3.00
4.00	Speech Pathology	5.00	13,810	0	13,810	126	109.60	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	56,676		56,676	1,482	38.24	6.00
7.00	Total (sum of lines 1-6)		2,192,171	0	2,192,171	11,965		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	9			8.00
8.01	Skilled Nursing Care		26900	0	6			8.01
8.02	Skilled Nursing Care		34620	0	34			8.02
8.03	Skilled Nursing Care		99915	0	1,529			8.03
9.00	Physical Therapy		17140	0	18			9.00
9.01	Physical Therapy		26900	0	13			9.01
9.02	Physical Therapy		34620	0	62			9.02
9.03	Physical Therapy		99915	0	1,856			9.03
10.00	Occupational Therapy		17140	0	0			10.00
10.01	Occupational Therapy		26900	0	0			10.01
10.02	Occupational Therapy		34620	0	0			10.02
10.03	Occupational Therapy		99915	0	329			10.03
11.00	Speech Pathology		17140	0	0			11.00
11.01	Speech Pathology		26900	0	0			11.01
11.02	Speech Pathology		34620	0	0			11.02
11.03	Speech Pathology		99915	0	70			11.03
12.00	Medical Social Services		17140	0	0			12.00
12.01	Medical Social Services		26900	0	0			12.01
12.02	Medical Social Services		34620	0	0			12.02
12.03	Medical Social Services		99915	0	0			12.03
13.00	Home Health Aide		17140	0	0			13.00
13.01	Home Health Aide		26900	0	0			13.01
13.02	Home Health Aide		34620	0	0			13.02
13.03	Home Health Aide		99915	0	547			13.03
14.00	Total (sum of lines 8-13)			0	4,473			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part I | Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,578		0	346,434		1.00
2.00	Physical Therapy	0	1,949		0	322,443		2.00
3.00	Occupational Therapy	0	329		0	149,517		3.00
4.00	Speech Pathology	0	70		0	7,672		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	547		0	20,917		6.00
7.00	Total (sum of lines 1-6)	0	4,473		0	846,983		7.00

	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	1,196	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part I | Date/Time Prepared: 7/30/2021 9:15 am

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	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	346,434		1.00
2.00	Physical Therapy	322,443		2.00
3.00	Occupational Therapy	149,517		3.00
4.00	Speech Pathology	7,672		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	20,917		6.00
7.00	Total (sum of lines 1-6)	846,983		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-3 Part II | Date/Time Prepared: 7/30/2021 9:15 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	1.009971	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.577770	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.674580	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.170158	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.429626	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2020 To 12/31/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 7/30/2021 9:15 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	614,897	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	55,560	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,959	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,293	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	20,691	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	699,400	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	699,400	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	699,400	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	699,400	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	699,400	31.00
31.01	Sequestration adjustment (see instructions)	0	5,044	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	694,356	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0030 HHA CCN: 15-7430

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

Worksheet H-5

Date/Time Prepared: 7/30/2021 9:15 am

Home Health Agency I

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		0		694,356	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			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			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. H-4, Part II, column as appropriate, line 32)		0		694,356	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		694,356	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	6,026	6,026	-6,026	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	80,139	374,019	454,158	0	454,158	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	72,191	72,191	0	72,191	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	346	346	0	346	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	27,375	0	27,375	0	27,375	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	338,747	0	338,747	0	338,747	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	36,957	0	36,957	0	36,957	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	30,308	0	30,308	0	30,308	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	513,526	452,582	966,108	-6,026	960,082	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	-15,674	438,484		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	72,191		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	346		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	27,375		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	338,747		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	36,957		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	30,308		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-15,674	944,408		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-2 | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	27,105	0	27,105	0	27,105	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	335,411	0	335,411	0	335,411	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	36,593	0	36,593	0	36,593	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	30,010	0	30,010	0	30,010	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	429,119	0	429,119	0	429,119	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	27,105		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	335,411		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	36,593		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	30,010		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	429,119		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-3 Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	144	0	144	0	144	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,779	0	1,779	0	1,779	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	194	0	194	0	194	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	159	0	159	0	159	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	2,276	0	2,276	0	2,276	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	144		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,779		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	194		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	159		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	2,276		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-4 | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	126	0	126	0	126	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,557	0	1,557	0	1,557	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	170	0	170	0	170	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	139	0	139	0	139	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,992	0	1,992	0	1,992	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	126		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,557		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	170		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	139		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,992		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-5

Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	167,145	167,145	3.00
4.00	ADMINISTRATIVE & GENERAL	438,484	218,669	657,153	4.00
5.00	PLANT OPERATION & MAINTENANCE	72,191	62,613	134,804	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	346	2,057	2,403	10.00
11.00	MEDICAL RECORDS	0	4,239	4,239	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	429,119		429,119	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,276		2,276	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,992		1,992	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	944,408	454,723	1,399,131	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	167,145	0	0	167,145		3.00
4.00	ADMINISTRATIVE & GENERAL	657,153	0	0	0	657,153	4.00
5.00	PLANT OPERATION & MAINTENANCE	134,804	0	0	0	134,804	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,403	0	0	0	2,403	10.00
11.00	MEDICAL RECORDS	4,239	0	0	0	4,239	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	429,119			165,499	594,618	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,276	0	0	878	3,154	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,992	0	0	768	2,760	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,399,131	0	0	167,145	1,399,131	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	657,153					4.00
5.00	PLANT OPERATION & MAINTENANCE	119,393	254,197				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,128	0		0		10.00
11.00	MEDICAL RECORDS	3,754	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	526,641					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,793	135,571	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,444	118,626	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	657,153	254,197	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	4,531				10.00
11.00	MEDICAL RECORDS	0		7,993			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	4,486	7,914	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	24	42	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	21	37	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	4,531	7,993	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		1,133,659	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	141,584	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	123,888	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	1,399,131	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
7/30/2021 9:15 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	167,192			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-657,153	741,978	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	134,804	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	2,403	10.00
11.00	MEDICAL RECORDS	0	0	0	0	4,239	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			165,546	0	594,618	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	878	0	3,154	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	768	0	2,760	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	167,145		657,153	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.999719		0.885677	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	295,900					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	157,813	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	138,087	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	254,197	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.859064	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,570					10.00
11.00	MEDICAL RECORDS		4,570				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4,525	4,525	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24	24	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	21	21	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	4,531	7,993	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.991466	1.749015	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-7

Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	1.009971	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.577770	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.674580	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.429626	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.187495	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.170158	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC REHAB	76.00	0.279163	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC REHAB	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-8 | Date/Time Prepared: 7/30/2021 9:15 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,133,659	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,525	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			250.53	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,497	0		9.00
10.00	Program cost (line 8 times line 9)	876,103	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			141,584	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			24	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			5,899.33	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	24	0		14.00
15.00	Program cost (line 13 times line 14)	141,584	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			123,888	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			21	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			5,899.43	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	21	0		19.00
20.00	Program cost (line 18 times line 19)	123,888	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,399,131	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			4,570	22.00
23.00	Average cost per diem (line 21 divided by line 22)			306.16	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	577,163	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,135	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	21.58	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)	582,298	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/30/2021 9:15 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,517,596	21,843	1,539,439	-96,423	1,443,016	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	631,946	0	631,946	10,022	641,968	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	435,284	60	435,344	0	435,344	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	79,340	0	79,340	0	79,340	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	401,835	0	401,835	0	401,835	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,066,001	21,903	3,087,904	-86,401	3,001,503	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	146,713	146,713	0	146,713	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	53,850	53,850	0	53,850	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	200,563	200,563	0	200,563	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,066,001	222,466	3,288,467	-86,401	3,202,066	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	549,586	549,586	0	549,586	29.00
30.00	Administrative Costs	1,018,723	1,060,535	2,079,258	-693,199	1,386,059	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,018,723	1,610,121	2,628,844	-693,199	1,935,645	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,084,724	1,832,587	5,917,311	-779,600	5,137,711	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/30/2021 9:15 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,443,016		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	641,968		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	435,344		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	79,340		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	401,835		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,001,503		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	146,713		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	53,850		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	200,563		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,202,066		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-273,932	275,654		29.00
30.00	Administrative Costs	-172,165	1,213,894		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-446,097	1,489,548		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-446,097	4,691,614		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030
Component CCN: 15-8525

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

Worksheet M-1
Date/Time Prepared: 7/30/2021 9:15 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,497,790	27,471	3,525,261	96,423	3,621,684	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,838,609	0	1,838,609	0	1,838,609	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	364,394	0	364,394	0	364,394	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	43,510	43,510	66,304	109,814	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,009,854	0	1,009,854	0	1,009,854	9.00
10.00	Subtotal (sum of lines 1 through 9)	6,710,647	70,981	6,781,628	162,727	6,944,355	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	437,502	437,502	0	437,502	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	437,502	437,502	0	437,502	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,710,647	508,483	7,219,130	162,727	7,381,857	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,439,634	1,439,634	0	1,439,634	29.00
30.00	Administrative Costs	860,136	1,669,958	2,530,094	-1,102,761	1,427,333	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	860,136	3,109,592	3,969,728	-1,102,761	2,866,967	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	7,570,783	3,618,075	11,188,858	-940,034	10,248,824	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/30/2021 9:15 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-1,291,308	2,330,376		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,838,609		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	364,394		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	109,814		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,009,854		9.00
10.00	Subtotal (sum of lines 1 through 9)	-1,291,308	5,653,047		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	437,502		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	437,502		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,291,308	6,090,549		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-707,983	731,651		29.00
30.00	Administrative Costs	-306,071	1,121,262		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,014,054	1,852,913		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,305,362	7,943,462		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030
Component CCN: 15-8556

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

Worksheet M-1
Date/Time Prepared: 7/30/2021 9:15 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	24,667	972	25,639	0	25,639	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	149,734	0	149,734	0	149,734	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	20,851	1	20,852	0	20,852	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	352	352	0	352	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	50,635	0	50,635	0	50,635	9.00
10.00	Subtotal (sum of lines 1 through 9)	245,887	1,325	247,212	0	247,212	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,088	23,088	0	23,088	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,088	23,088	0	23,088	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	245,887	24,413	270,300	0	270,300	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	172,489	172,489	0	172,489	29.00
30.00	Administrative Costs	46,541	120,453	166,994	-55,257	111,737	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	46,541	292,942	339,483	-55,257	284,226	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	292,428	317,355	609,783	-55,257	554,526	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/30/2021 9:15 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	25,639		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	149,734		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	20,852		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	352		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	50,635		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	247,212		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	23,088		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,088		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	270,300		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-120,917	51,572		29.00
30.00	Administrative Costs	0	111,737		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-120,917	163,309		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-120,917	433,609		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030
Component CCN: 15-8520

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

Worksheet M-2
Date/Time Prepared: 7/30/2021 9:15 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.89	12,954	1	4		1.00
2.00	Physician Assistant	0.57	767	1	1		2.00
3.00	Nurse Practitioner	2.97	5,332	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.43	19,053		8	19,053	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.87	1,049			1,049	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.30	20,102			20,102	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,202,066	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,202,066	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,489,548	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,704,549	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,194,097	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,194,097	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,194,097	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,396,163	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/30/2021 9:15 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	6.21	21,297	1	6		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	10.53	24,301	1	11		3.00
4.00	Subtotal (sum of lines 1 through 3)	16.74	45,598		17	45,598	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.64	1,058			1,058	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	17.38	46,656			46,656	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					6,090,549	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					6,090,549	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,852,913	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					7,002,129	15.00
16.00	Total overhead (sum of lines 14 and 15)					8,855,042	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					8,855,042	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					8,855,042	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					14,945,591	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8556 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/30/2021 9:15 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.07	227	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.91	1,652	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.98	1,879		1	1,879	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.98	1,879			1,879	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					270,300	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					270,300	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					163,309	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					346,234	15.00
16.00	Total overhead (sum of lines 14 and 15)					509,543	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					509,543	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					509,543	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					779,843	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			8,396,163	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			241,743	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,154,420	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,102	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			20,102	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			405.65	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	405.65	405.65		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,914		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,399,014		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,399,014		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,016,449		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		168,369		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		397,382		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,510,872		16.04
16.05	Total program cost (see instructions)	0	1,908,254		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		113,042		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		147,008		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,908,254		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		87,118		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,995,372		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,995,372		26.00
26.01	Sequestration adjustment (see instructions)		13,169		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,233,503		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		748,700		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			14,945,591	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,133,785	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			13,811,806	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			46,656	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			46,656	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			296.03	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	296.03	296.03		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,181		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,829,761		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,829,761		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,183,819		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		291,988		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		451,309		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,003,090		16.04
16.05	Total program cost (see instructions)	0	1,454,399		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		124,590		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		152,955		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,454,399		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		154,041		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,608,440		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,608,440		26.00
26.01	Sequestration adjustment (see instructions)		10,616		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,172,855		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		424,969		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8556	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			779,843	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			27,469	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			752,374	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,879	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,879	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			400.41	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	400.41	400.41		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	248		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	99,302		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	99,302		16.00
16.01	Total program charges (see instructions)(from contractor's records)		40,884		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,434		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		30,201		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		54,482		16.04
16.05	Total program cost (see instructions)	0	84,683		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		998		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,490		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		84,683		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,090		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		90,773		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		90,773		26.00
26.01	Sequestration adjustment (see instructions)		599		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		13,410		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		76,764		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,001,503	3,001,503	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000929	0.004240	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,788	12,726	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	36,700	39,980	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	39,488	52,706	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,202,066	3,202,066	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,194,097	5,194,097	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.012332	0.016460	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	64,054	85,495	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	103,542	138,201	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	256	1,169	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	404.46	118.22	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	109	364	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	44,086	43,032	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		241,743	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		87,118	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	5,653,047	5,653,047	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003269	0.006407	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	18,480	36,219	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	277,545	129,789	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	296,025	166,008	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	6,090,549	6,090,549	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	8,855,042	8,855,042	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.048604	0.027257	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	430,390	241,362	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	726,415	407,370	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,936	3,795	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	375.21	107.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	206	715	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	77,293	76,748	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		1,133,785	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		154,041	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0030 Component CCN: 15-8556	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/30/2021 9:15 am
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	247,212	247,212	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000926	0.003895	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	229	963	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,157	4,172	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,386	5,135	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	270,300	270,300	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	509,543	509,543	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016226	0.018997	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,268	9,680	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,654	14,815	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	29	122	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	436.34	121.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	25	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,054	3,036	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		27,469	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		6,090	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/30/2021 9:15 am

			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1,233,503	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			1,233,503	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			748,700	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			1,982,203	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/30/2021 9:15 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,172,855	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,172,855	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		424,969	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,597,824	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8556	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/30/2021 9:15 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		13,410	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		13,410	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		76,764	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		90,174	7.00

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