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: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/14/2021 11:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/14/2021 Time: 11:18 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 PROVI PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE A 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 INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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) MICHAEL CRAIG
Officer or Administrator of Provider(s)

CFIEF FINANCIAL OFFICER
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	355,909	-577,422	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-2,588	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	353,321	-577,422	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it dis a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to com and review the information collection is estimated 673 hours per response, including the time to review instructions, search exis 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 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 R 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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/14/2021 11:18 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/14/2021 11:18 am

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

		Urban/Rural St	Date of Geogra	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:18 am

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

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

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

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

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

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

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

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

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		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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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

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		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	60,672	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/14/2021 11:18 am

		1.00	2.00	
	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	15H059	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: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:18 am

		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)	Y	159	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/14/2021 11:18 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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/02/2021	Y	04/02/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/14/2021 11:18 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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

		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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/14/2021 11:18 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	19	6,954	92,328.00	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)		19	6,954	92,328.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	33,744.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	126,072.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/14/2021 11:18 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,928	95	3,847			1.00
2.00	HMO and other (see instructions)	1,027	386				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	42	0	42			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	27			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,970	95	3,916			7.00
8.00	INTENSIVE CARE UNIT	662	49	1,406			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)	2,632	144	5,322	0.00	242.80	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			25			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	242.80	27.00
28.00	Observation Bed Days		11	1,264			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/14/2021 11:18 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	705	31	1,414	1.00
2.00	HMO and other (see instructions)			271	119		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	705	31	1,414	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/14/2021 11:18 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)	0.236235	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,523,499	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	34,697,055	6.00
7.00	Medicaid cost (line 1 times line 6)	8,196,659	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)	2,673,160	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)	6,477	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	62,626	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	14,794	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)	8,317	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,681,477	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)	3,933,719	149,233	4,082,952	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	929,282	149,233	1,078,515	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)	929,282	149,233	1,078,515	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)	5,428,741	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	316,707	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	487,242	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,941,499	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,337,890	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,416,405	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,097,882	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	491,768	491,768	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,211,761	1,211,761	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	82,995	273,254	356,249	3,216,781	3,573,030	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,239,580	14,374,319	15,613,899	-285,924	15,327,975	5.00
7.00	00700	OPERATION OF PLANT	674,708	1,490,571	2,165,279	-289,532	1,875,747	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,427	138,427	-316	138,111	8.00
9.00	00900	HOUSEKEEPING	422,556	344,263	766,819	-155,475	611,344	9.00
10.00	01000	DIETARY	437,493	367,103	804,596	-238,063	566,533	10.00
11.00	01100	CAFETERIA	0	0	0	152,124	152,124	11.00
13.00	01300	NURSING ADMINISTRATION	1,541,739	2,020,734	3,562,473	-322,005	3,240,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,344	119,382	179,726	975,177	1,154,903	14.00
15.00	01500	PHARMACY	603,912	12,445,122	13,049,034	-11,909,399	1,139,635	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	52,291	52,291	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,429,526	2,055,675	4,485,201	-689,096	3,796,105	30.00
31.00	03100	INTENSIVE CARE UNIT	1,343,322	867,505	2,210,827	-460,895	1,749,932	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,165,411	1,455,346	2,620,757	-735,096	1,885,661	50.00
51.00	05100	RECOVERY ROOM	333,715	88,033	421,748	-65,520	356,228	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	989,200	1,157,665	2,146,865	-660,251	1,486,614	54.00
56.00	05600	RADIOISOTOPE	93,986	271,274	365,260	-172,193	193,067	56.00
57.00	05700	CT SCAN	362,636	251,524	614,160	-209,136	405,024	57.00
58.00	05800	MRI	225,151	117,882	343,033	-86,589	256,444	58.00
60.00	06000	LABORATORY	296,159	3,585,937	3,882,096	-24,730	3,857,366	60.00
65.00	06500	RESPIRATORY THERAPY	759,886	385,407	1,145,293	-324,937	820,356	65.00
66.00	06600	PHYSICAL THERAPY	637,681	188,968	826,649	-132,480	694,169	66.00
67.00	06700	OCCUPATIONAL THERAPY	356,856	78,247	435,103	-59,391	375,712	67.00
68.00	06800	SPEECH PATHOLOGY	69,406	20,497	89,903	-15,894	74,009	68.00
69.00	06900	ELECTROCARDIOLOGY	334,141	705,396	1,039,537	-255,486	784,051	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	204,949	204,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	95,209	95,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,910,252	11,910,252	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	69,758	69,758	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	882,127	391,210	1,273,337	-244,186	1,029,151	90.00
90.01	09001	CLINIC - DIABETES	16,642	54,803	71,445	-188	71,257	90.01
91.00	09100	EMERGENCY	2,082,350	1,654,125	3,736,475	-708,522	3,027,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,441,522	44,902,669	62,344,191	334,766	62,678,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,713	14,576	33,289	-13,909	19,380	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	307,720	307,720	-246,194	61,526	192.00
194.00	07950	OCCUPATIONAL HEALTH	48,740	38,322	87,062	-10,161	76,901	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	159,846	74,848	234,694	-64,461	170,233	194.02
194.03	07953	HOME CARE	0	41	41	-41	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	17,668,821	45,338,176	63,006,997	0	63,006,997	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	171,555	663,323	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	323,774	1,535,535	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	450,593	4,023,623	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-796,925	14,531,050	5.00
7.00	00700	OPERATION OF PLANT	-56,591	1,819,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-766	137,345	8.00
9.00	00900	HOUSEKEEPING	0	611,344	9.00
10.00	01000	DIETARY	26,920	593,453	10.00
11.00	01100	CAFETERIA	-103,995	48,129	11.00
13.00	01300	NURSING ADMINISTRATION	-1,508,430	1,732,038	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2	1,154,901	14.00
15.00	01500	PHARMACY	99,199	1,238,834	15.00
17.00	01700	SOCIAL SERVICE	0	52,291	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-976,767	2,819,338	30.00
31.00	03100	INTENSIVE CARE UNIT	-243,858	1,506,074	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-960,881	924,780	50.00
51.00	05100	RECOVERY ROOM	0	356,228	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-127,717	1,358,897	54.00
56.00	05600	RADIOISOTOPE	0	193,067	56.00
57.00	05700	CT SCAN	0	405,024	57.00
58.00	05800	MRI	0	256,444	58.00
60.00	06000	LABORATORY	-283,428	3,573,938	60.00
65.00	06500	RESPIRATORY THERAPY	-62,822	757,534	65.00
66.00	06600	PHYSICAL THERAPY	119,592	813,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	-2,250	373,462	67.00
68.00	06800	SPEECH PATHOLOGY	0	74,009	68.00
69.00	06900	ELECTROCARDIOLOGY	0	784,051	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	204,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,910,252	73.00
76.97	07697	CARDIAC REHABILITATION	0	69,758	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	1,029,151	90.00
90.01	09001	CLINIC - DIABETES	16,094	87,351	90.01
91.00	09100	EMERGENCY	-83,753	2,944,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,000,458	58,678,499	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,380	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	61,526	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	76,901	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	170,233	194.02
194.03	07953	HOME CARE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,000,458	59,006,539	200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:18 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,974,799	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	0		0	2,974,799	
	B - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	64,396	87,728	1.00
	0		64,396	87,728	
	C - CAPITAL LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	591	1.00
	0		0	591	
	D - CARDIOLOGY				
1.00	CARDIAC REHABILITATION	76.97	58,023	11,735	1.00
	0		58,023	11,735	
	E - DEPR EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	446,536	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,201,090	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	0		0	1,647,626	
	F - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,910,252	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

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00		0.00	0	0	7.00
	0		0	11,910,252	
	G - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	95,209	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
	0		0	95,209	
	H - ACCRUED PTO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		243,957	1.00
2.00	HOUSEKEEPING	9.00		1,305	2.00
3.00	DIETARY	10.00		8,460	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		7,175	4.00
5.00	CT SCAN	57.00		1,087	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00		0	8.00
9.00		0.00		0	9.00
10.00		0.00		0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00		0	21.00
	0		0	261,984	
	I - BILLABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		204,949	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	204,949	
	J - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,641	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,671	2.00
	0		0	55,312	
	L - SOCIAL WORKER				
1.00	SOCIAL SERVICE	17.00	52,291	0	1.00
	0		52,291	0	
	M - NONBILLABLE DRUGS				
1.00	PHARMACY	15.00		21,398	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		28	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
	TOTALS		0	21,426	
	N - NONBILLABLE MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,036,232	1.00
2.00	OPERATION OF PLANT	7.00	0	621	2.00
3.00	NURSING ADMINISTRATION	13.00	0	4,151	3.00
4.00	RADIOISOTOPE	56.00	0	3,017	4.00
5.00	CLINIC - DIABETES	90.01	0	6	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2	6.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:18 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	1,044,029	
500.00	Grand Total: Increases		174,710	18,315,640	500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:18 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00		150,837	0	1.00
2.00	OPERATION OF PLANT	7.00		117,831	0	2.00
3.00	HOUSEKEEPING	9.00		118,469	0	3.00
4.00	DIETARY	10.00		73,154	0	4.00
5.00	NURSING ADMINISTRATION	13.00		231,130	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00		27,143	0	6.00
7.00	PHARMACY	15.00		74,822	0	7.00
8.00	ADULTS & PEDIATRICS	30.00		447,306	0	8.00
9.00	INTENSIVE CARE UNIT	31.00		218,984	0	9.00
10.00	OPERATING ROOM	50.00		167,384	0	10.00
11.00	RECOVERY ROOM	51.00		63,917	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00		237,317	0	12.00
13.00	RADIOISOTOPE	56.00		15,822	0	13.00
14.00	CT SCAN	57.00		39,425	0	14.00
15.00	MRI	58.00		30,543	0	15.00
16.00	LABORATORY	60.00		24,384	0	16.00
17.00	RESPIRATORY THERAPY	65.00		144,133	0	17.00
18.00	PHYSICAL THERAPY	66.00		108,002	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00		52,347	0	19.00
20.00	SPEECH PATHOLOGY	68.00		15,455	0	20.00
21.00	ELECTROCARDIOLOGY	69.00		39,643	0	21.00
22.00	CLINIC	90.00		141,609	0	22.00
23.00	EMERGENCY	91.00		360,408	0	23.00
24.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00		13,295	0	24.00
25.00	OCCUPATIONAL HEALTH	194.00		7,476	0	25.00
26.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		53,963	0	26.00
	0		0	2,974,799		
	B - DIETARY/CAFETERIA					
1.00	DIETARY	10.00	64,396	87,728	0	1.00
	0		64,396	87,728		
	C - CAPITAL LEASE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	591	11	1.00
	0		0	591		
	D - CARDIOLOGY					
1.00	ELECTROCARDIOLOGY	69.00	58,023	11,735	0	1.00
	0		58,023	11,735		
	E - DEPR EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,727	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	14,829	9	2.00
3.00	OPERATION OF PLANT	7.00	0	159,352	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	316	0	4.00
5.00	HOUSEKEEPING	9.00	0	232	0	5.00
6.00	DIETARY	10.00	0	18,555	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	14,949	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,472	0	8.00
9.00	PHARMACY	15.00	0	34,895	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	33,874	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	91,987	0	11.00
12.00	OPERATING ROOM	50.00	0	194,767	0	12.00
13.00	RECOVERY ROOM	51.00	0	265	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	376,934	0	14.00
15.00	RADIOISOTOPE	56.00	0	86,934	0	15.00
16.00	CT SCAN	57.00	0	86,270	0	16.00
17.00	MRI	58.00	0	26,567	0	17.00
18.00	LABORATORY	60.00	0	337	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	16,144	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	7,107	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	109,998	0	21.00
22.00	CLINIC	90.00	0	1,760	0	22.00
23.00	CLINIC - DIABETES	90.01	0	194	0	23.00
24.00	EMERGENCY	91.00	0	85,787	0	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	245,605	0	25.00
26.00	OCCUPATIONAL HEALTH	194.00	0	272	0	26.00
27.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	8,456	0	27.00
28.00	HOME CARE	194.03	0	41	0	28.00
	0		0	1,647,626		
	F - BILLABLE DRUGS					
1.00	PHARMACY	15.00	0	11,779,106	0	1.00
2.00	OPERATING ROOM	50.00	0	592	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,092	0	3.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
4.00	RADIOISOTOPE	56.00	0	71,763	0	4.00
5.00	CT SCAN	57.00	0	35,464	0	5.00
6.00	MRI	58.00	0	20,238	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	997	0	7.00
	0		0	11,910,252		
	G - IMPLANT SUPPLIES					
1.00	INTENSIVE CARE UNIT	31.00		12	0	1.00
2.00	OPERATING ROOM	50.00		94,629	0	2.00
3.00	CLINIC	90.00		151	0	3.00
4.00	EMERGENCY	91.00		417	0	4.00
	0		0	95,209		
	H - ACCRUED PTO					
1.00	ADMINISTRATIVE & GENERAL	5.00		18,879	0	1.00
2.00	OPERATION OF PLANT	7.00		12,970	0	2.00
3.00	NURSING ADMINISTRATION	13.00		27,750	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		1,796	0	4.00
5.00	PHARMACY	15.00		4,389	0	5.00
6.00	ADULTS & PEDIATRICS	30.00		35,041	0	6.00
7.00	INTENSIVE CARE UNIT	31.00		13,072	0	7.00
8.00	OPERATING ROOM	50.00		46,798	0	8.00
9.00	RECOVERY ROOM	51.00		1,338	0	9.00
10.00	RADIOISOTOPE	56.00		691	0	10.00
11.00	MRI	58.00		7,964	0	11.00
12.00	RESPIRATORY THERAPY	65.00		19,571	0	12.00
13.00	PHYSICAL THERAPY	66.00		7,696	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00		7,044	0	14.00
15.00	SPEECH PATHOLOGY	68.00		439	0	15.00
16.00	ELECTROCARDIOLOGY	69.00		3,123	0	16.00
17.00	CLINIC	90.00		18,134	0	17.00
18.00	EMERGENCY	91.00		30,380	0	18.00
19.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00		614	0	19.00
20.00	OCCUPATIONAL HEALTH	194.00		2,344	0	20.00
21.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		1,951	0	21.00
	0		0	261,984		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00		775	0	1.00
2.00	DIETARY	10.00		78	0	2.00
3.00	NURSING ADMINISTRATION	13.00		36	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		2,672	0	4.00
5.00	PHARMACY	15.00		126	0	5.00
6.00	ADULTS & PEDIATRICS	30.00		7,958	0	6.00
7.00	INTENSIVE CARE UNIT	31.00		1,099	0	7.00
8.00	OPERATING ROOM	50.00		157,118	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		7,179	0	9.00
10.00	CT SCAN	57.00		1,860	0	10.00
11.00	RESPIRATORY THERAPY	65.00		605	0	11.00
12.00	PHYSICAL THERAPY	66.00		502	0	12.00
13.00	ELECTROCARDIOLOGY	69.00		2,554	0	13.00
14.00	CLINIC	90.00		2,193	0	14.00
15.00	EMERGENCY	91.00		20,194	0	15.00
	0		0	204,949		
	J - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55,312	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	55,312		
	L - SOCIAL WORKER					
1.00	NURSING ADMINISTRATION	13.00	52,291	0	0	1.00
	0		52,291	0		
	M - NONBILLABLE DRUGS					
1.00	ADULTS & PEDIATRICS	30.00		4,884	0	1.00
2.00	INTENSIVE CARE UNIT	31.00		3,210	0	2.00
3.00	OPERATING ROOM	50.00		881	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		4,458	0	4.00
5.00	CT SCAN	57.00		739	0	5.00
6.00	RESPIRATORY THERAPY	65.00		2,133	0	6.00
7.00	PHYSICAL THERAPY	66.00		130	0	7.00
8.00	CLINIC	90.00		2,255	0	8.00
9.00	EMERGENCY	91.00		2,736	0	9.00
	TOTALS		0	21,426		

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 Date/Time Prepared: 7/14/2021 11:18 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	N - NONBILLABLE MEDICAL SUPPLIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	248	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	45,292	0	2.00
3.00	HOUSEKEEPING	9.00	0	38,079	0	3.00
4.00	DIETARY	10.00	0	2,612	0	4.00
5.00	PHARMACY	15.00	0	37,459	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	160,033	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	132,531	0	7.00
8.00	OPERATING ROOM	50.00	0	72,927	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	39,446	0	9.00
10.00	CT SCAN	57.00	0	46,465	0	10.00
11.00	MRI	58.00	0	1,277	0	11.00
12.00	LABORATORY	60.00	0	9	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	142,351	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	9,043	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	29,413	0	15.00
16.00	CLINIC	90.00	0	78,084	0	16.00
17.00	EMERGENCY	91.00	0	208,600	0	17.00
18.00	OCCUPATIONAL HEALTH	194.00	0	69	0	18.00
19.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	91	0	19.00
	TOTALS		0	1,044,029		
500.00	Grand Total: Decreases		174,710	18,315,640		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I Date/Time Prepared: 7/14/2021 11:18 am

		Beginning Balances	Acquisitions Purchases	Donation	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	931,334	0	0	0	0	1.00
2.00	Land Improvements	1,119,735	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,290,100	0	0	0	223,752	3.00
4.00	Building Improvements	5,169,109	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,393,134	689,328	0	689,328	689,112	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,903,412	689,328	0	689,328	912,864	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,903,412	689,328	0	689,328	912,864	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	931,334	0	1.00
2.00	Land Improvements	1,119,735	0	2.00
3.00	Buildings and Fixtures	14,066,348	0	3.00
4.00	Building Improvements	5,169,109	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,393,350	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,679,876	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,679,876	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 7/14/2021 11:18 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1328

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

Worksheet A-7 Part III
Date/Time Prepared: 7/14/2021 11:18 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,286,526	0	21,286,526	0.580333	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,393,350	0	15,393,350	0.419667	0	2.00
3.00	Total (sum of lines 1-2)	36,679,876	0	36,679,876	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	446,528	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,524,864	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,971,392	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	172,154	44,641	0	0	663,323	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,671	0	0	1,535,535	2.00
3.00	Total (sum of lines 1-2)	172,154	55,312	0	0	2,198,858	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/14/2021 11:18 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-661,711	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,928,574			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	7,906,653			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-35,258	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-17,634	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 Date/Time Prepared: 7/14/2021 11:18 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	
34.00	MISCELLANEOUS INCOME	B	-1,559	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-766	LAUNDRY & LINEN SERVICE	8.00	0	35.00
35.01	MISCELLANEOUS INCOME	B	-9	DIETARY	10.00	0	35.01
36.00	MISCELLANEOUS INCOME	B	-103,995	CAFETERIA	11.00	0	36.00
37.00	MISCELLANEOUS INCOME	B	-33,540	NURSING ADMINISTRATION	13.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-140	ADULTS & PEDIATRICS	30.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-152	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	MISCELLANEOUS INCOME	B	-62,822	RESPIRATORY THERAPY	65.00	0	40.00
40.01	MISCELLANEOUS INCOME	B	-2,250	OCCUPATIONAL THERAPY	67.00	0	40.01
41.00	MISCELLANEOUS INCOME	B	0	ELECTROCARDIOLOGY	69.00	0	41.00
45.00	INVESTMENT FEES	B	6,361	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	PHONES	A	-8	CAP REL COSTS-BLDG & FIXT	1.00	9	45.01
45.02	PHONES	A	-2,935	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03	PHONES	A	-7,119	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PHONES	A	-22,813	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PHONES	A	-2	CENTRAL SERVICES & SUPPLY	14.00	0	45.05
45.06	HAF	A	-3,026,866	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	CABLE	A	-990	OPERATION OF PLANT	7.00	0	45.07
45.08	CABLE	A	-1,753	PHYSICAL THERAPY	66.00	0	45.08
45.09	CABLE	A	-159	CLINIC - DIABETES	90.01	0	45.09
45.10	RECRUITING	A	-3,739	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	TELEPHONE EQUIPMENT	A	-1,725	ADULTS & PEDIATRICS	30.00	0	45.11
45.12	TELEPHONE EQUIPMENT	A	-82	PHARMACY	15.00	0	45.12
45.13	MARKETING	A	-18,611	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14	BENEFITS	A	-2,978,260	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,000,458				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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/14/2021 11:18 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	833,274	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	361,967	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,496,635	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	10,475,004	8,787,366	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	166,069	226,732	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	2,231,235	1,632,496	4.02
4.03	7.00	OPERATION OF PLANT	RELATED PARTY	0	54,042	4.03
4.04	10.00	DIETARY	RELATED PARTY	26,929	0	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	114,565	1,589,455	4.05
4.06	15.00	PHARMACY	RELATED PARTY	591,272	491,991	4.06
4.07	66.00	PHYSICAL THERAPY	RELATED PARTY	121,345	0	4.07
4.08	90.01	CLINIC - DIABETES	RELATED PARTY	70,399	54,146	4.08
4.09	91.00	EMERGENCY	EMERGENCY ROOM	2,947,394	693,207	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	3,231	3,231	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	3,380	3,380	4.11
4.12	10.00	DIETARY	SHARED EMPLOYEES	26,284	26,284	4.12
4.13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	1,169,882	1,169,882	4.13
4.14	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	292,629	292,629	4.14
4.15	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	6,535	6,535	4.15
4.16	60.00	LABORATORY	SHARED EMPLOYEES	3,377,938	3,377,938	4.16
4.17	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	447,813	447,813	4.17
4.18	90.00	CLINIC	SHARED EMPLOYEES	53,704	53,704	4.18
4.19	90.01	CLINIC - DIABETES	SHARED EMPLOYEES	16,642	16,642	4.19
4.20	91.00	EMERGENCY	SHARED EMPLOYEES	5,167	5,167	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,839,293	18,932,640	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 h not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office: Name	Related Organization(s) and/or Home Office: 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 t 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under titl XVIII.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/14/2021 11:18 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	833,274	11		1.00
2.00	361,967	9		2.00
3.00	3,496,635	0		3.00
4.00	1,687,638	0		4.00
4.01	-60,663	0		4.01
4.02	598,739	0		4.02
4.03	-54,042	0		4.03
4.04	26,929	0		4.04
4.05	-1,474,890	0		4.05
4.06	99,281	0		4.06
4.07	121,345	0		4.07
4.08	16,253	0		4.08
4.09	2,254,187	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
5.00	7,906,653			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 h 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 t 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under titl XVIII.

6.00	HOME OFFICE		6.00
7.00	HEALTHCARE		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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/14/2021 11:18 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,169,882	974,902	194,980	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	292,629	243,858	48,771	0	0	2.00
3.00	50.00	OPERATING ROOM	960,881	960,881	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	127,565	127,565	0	0	0	4.00
5.00	60.00	LABORATORY	295,465	283,428	12,037	0	0	5.00
6.00	91.00	EMERGENCY	2,731,777	2,337,940	393,837	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			5,578,199	4,928,574	649,625		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	974,902	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	243,858	2.00
3.00	50.00	OPERATING ROOM	0	0	0	960,881	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	127,565	4.00
5.00	60.00	LABORATORY	0	0	0	283,428	5.00
6.00	91.00	EMERGENCY	0	0	0	2,337,940	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	0	0	4,928,574	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	663,323	663,323				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,535,535		1,535,535			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,023,623	2,083	6,537	4,032,243		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,531,050	97,165	304,977	284,222	15,217,414	5.00
7.00	00700	OPERATION OF PLANT	1,819,156	73,396	230,373	154,703	2,277,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,345	3,144	9,868	0	150,357	8.00
9.00	00900	HOUSEKEEPING	611,344	7,186	22,556	96,887	737,973	9.00
10.00	01000	DIETARY	593,453	15,541	48,779	85,547	743,320	10.00
11.00	01100	CAFETERIA	48,129	8,164	25,626	14,765	96,684	11.00
13.00	01300	NURSING ADMINISTRATION	1,732,038	22,355	70,167	341,514	2,166,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,154,901	17,683	55,502	13,836	1,241,922	14.00
15.00	01500	PHARMACY	1,238,834	5,017	15,746	138,470	1,398,067	15.00
17.00	01700	SOCIAL SERVICE	52,291	586	1,839	11,990	66,706	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,819,338	35,366	111,005	557,070	3,522,779	30.00
31.00	03100	INTENSIVE CARE UNIT	1,506,074	9,269	29,093	308,009	1,852,445	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	924,780	43,704	137,177	267,216	1,372,877	50.00
51.00	05100	RECOVERY ROOM	356,228	0	0	76,517	432,745	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,897	19,500	61,207	226,813	1,666,417	54.00
56.00	05600	RADIOISOTOPE	193,067	0	0	21,550	214,617	56.00
57.00	05700	CT SCAN	405,024	4,003	12,564	83,148	504,739	57.00
58.00	05800	MRI	256,444	4,248	13,335	51,625	325,652	58.00
60.00	06000	LABORATORY	3,573,938	18,388	57,714	67,906	3,717,946	60.00
65.00	06500	RESPIRATORY THERAPY	757,534	8,568	26,894	174,234	967,230	65.00
66.00	06600	PHYSICAL THERAPY	813,761	9,071	28,472	146,213	997,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	373,462	4,462	14,006	81,823	473,753	67.00
68.00	06800	SPEECH PATHOLOGY	74,009	1,053	3,306	15,914	94,282	68.00
69.00	06900	ELECTROCARDIOLOGY	784,051	19,528	61,294	63,311	928,184	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,949	0	0	0	204,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,209	0	0	0	95,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,910,252	0	0	0	11,910,252	73.00
76.97	07697	CARDIAC REHABILITATION	69,758	1,667	5,232	13,304	89,961	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,029,151	24,244	76,095	202,262	1,331,752	90.00
90.01	09001	CLINIC - DIABETES	87,351	2,118	6,649	3,816	99,934	90.01
91.00	09100	EMERGENCY	2,944,200	19,469	61,107	477,460	3,502,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,678,499	476,978	1,497,120	3,980,125	58,401,621	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,380	3,801	11,931	4,291	39,403	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,526	152,127	0	0	213,653	192.00
194.00	07950	OCCUPATIONAL HEALTH	76,901	8,438	26,484	11,176	122,999	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	170,233	21,979	0	36,651	228,863	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	59,006,539	663,323	1,535,535	4,032,243	59,006,539	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,217,414					5.00
7.00	00700	OPERATION OF PLANT	791,512	3,069,140				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,251	19,664	222,272			8.00
9.00	00900	HOUSEKEEPING	256,457	44,950	0	1,039,380		9.00
10.00	01000	DIETARY	258,316	97,206	0	52,745	1,151,587	10.00
11.00	01100	CAFETERIA	33,599	51,067	0	27,710	0	11.00
13.00	01300	NURSING ADMINISTRATION	752,745	139,828	0	75,872	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	431,588	110,605	0	60,015	0	14.00
15.00	01500	PHARMACY	485,851	31,378	0	17,026	0	15.00
17.00	01700	SOCIAL SERVICE	23,181	3,665	0	1,989	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,224,222	221,209	79,235	120,030	843,359	30.00
31.00	03100	INTENSIVE CARE UNIT	643,754	57,977	34,045	31,459	308,228	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	477,097	273,366	39,713	148,333	0	50.00
51.00	05100	RECOVERY ROOM	150,386	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,107	121,972	0	66,183	0	54.00
56.00	05600	RADIOISOTOPE	74,583	0	0	0	0	56.00
57.00	05700	CT SCAN	175,405	25,038	0	13,586	0	57.00
58.00	05800	MRI	113,169	26,574	0	14,419	0	58.00
60.00	06000	LABORATORY	1,292,046	115,013	0	62,407	0	60.00
65.00	06500	RESPIRATORY THERAPY	336,128	53,593	0	29,080	0	65.00
66.00	06600	PHYSICAL THERAPY	346,653	56,739	0	30,787	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,637	27,911	0	15,145	0	67.00
68.00	06800	SPEECH PATHOLOGY	32,765	6,588	0	3,575	0	68.00
69.00	06900	ELECTROCARDIOLOGY	322,559	122,145	0	66,277	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71,223	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,087	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,138,994	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	31,263	10,426	0	5,657	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	462,805	151,642	0	82,282	0	90.00
90.01	09001	CLINIC - DIABETES	34,729	13,250	0	7,189	0	90.01
91.00	09100	EMERGENCY	1,217,083	121,774	69,279	66,076	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,007,195	1,903,580	222,272	997,842	1,151,587	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,693	23,775	0	12,901	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,248	951,533	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	42,744	52,776	0	28,637	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	79,534	137,476	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	15,217,414	3,069,140	222,272	1,039,380	1,151,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	209,060					11.00
13.00	01300	NURSING ADMINISTRATION	15,415	3,149,934				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,927	0	1,846,057			14.00
15.00	01500	PHARMACY	6,744	0	107,763	2,046,829		15.00
17.00	01700	SOCIAL SERVICE	963	0	0	0	96,504	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,573	1,231,008	251,152	838	70,674	30.00
31.00	03100	INTENSIVE CARE UNIT	15,415	506,886	205,392	551	25,830	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,561	144,825	115,085	151	0	50.00
51.00	05100	RECOVERY ROOM	3,854	144,825	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,524	0	60,424	765	0	54.00
56.00	05600	RADIOISOTOPE	963	0	2,366	0	0	56.00
57.00	05700	CT SCAN	5,780	0	71,822	127	0	57.00
58.00	05800	MRI	2,890	0	3,740	0	0	58.00
60.00	06000	LABORATORY	18,305	0	16	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,634	0	212,615	366	0	65.00
66.00	06600	PHYSICAL THERAPY	8,671	0	13,705	22	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,854	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	963	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,854	72,412	44,687	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	300,606	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	139,647	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,043,153	0	73.00
76.97	07697	CARDIAC REHABILITATION	963	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,488	289,649	0	387	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	27,939	760,329	316,755	469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	203,280	3,149,934	1,845,775	2,046,829	96,504	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	963	0	109	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	3,854	0	173	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	209,060	3,149,934	1,846,057	2,046,829	96,504	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/14/2021 11:18 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	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	7,602,079	0	7,602,079	30.00
31.00	03100	INTENSIVE CARE UNIT	3,681,982	0	3,681,982	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,583,008	0	2,583,008	50.00
51.00	05100	RECOVERY ROOM	731,810	0	731,810	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,507,392	0	2,507,392	54.00
56.00	05600	RADIOISOTOPE	292,529	0	292,529	56.00
57.00	05700	CT SCAN	796,497	0	796,497	57.00
58.00	05800	MRI	486,444	0	486,444	58.00
60.00	06000	LABORATORY	5,205,733	0	5,205,733	60.00
65.00	06500	RESPIRATORY THERAPY	1,608,646	0	1,608,646	65.00
66.00	06600	PHYSICAL THERAPY	1,454,094	0	1,454,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	685,300	0	685,300	67.00
68.00	06800	SPEECH PATHOLOGY	138,173	0	138,173	68.00
69.00	06900	ELECTROCARDIOLOGY	1,560,118	0	1,560,118	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	576,778	0	576,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	267,943	0	267,943	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,092,399	0	18,092,399	73.00
76.97	07697	CARDIAC REHABILITATION	138,270	0	138,270	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,332,005	0	2,332,005	90.00
90.01	09001	CLINIC - DIABETES	155,102	0	155,102	90.01
91.00	09100	EMERGENCY	6,081,940	0	6,081,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,978,242	0	56,978,242	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	90,735	0	90,735	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,239,434	0	1,239,434	192.00
194.00	07950	OCCUPATIONAL HEALTH	248,228	0	248,228	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	449,900	0	449,900	194.02
194.03	07953	HOME CARE	0	0	0	194.03
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)	59,006,539	0	59,006,539	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,083	6,537	8,620	8,620	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	97,165	304,977	402,142	607	5.00
7.00	00700	OPERATION OF PLANT	0	73,396	230,373	303,769	331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,144	9,868	13,012	0	8.00
9.00	00900	HOUSEKEEPING	0	7,186	22,556	29,742	207	9.00
10.00	01000	DIETARY	0	15,541	48,779	64,320	183	10.00
11.00	01100	CAFETERIA	0	8,164	25,626	33,790	32	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,355	70,167	92,522	730	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,683	55,502	73,185	30	14.00
15.00	01500	PHARMACY	0	5,017	15,746	20,763	296	15.00
17.00	01700	SOCIAL SERVICE	0	586	1,839	2,425	26	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,366	111,005	146,371	1,194	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,269	29,093	38,362	658	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,704	137,177	180,881	571	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	164	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,500	61,207	80,707	485	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	46	56.00
57.00	05700	CT SCAN	0	4,003	12,564	16,567	178	57.00
58.00	05800	MRI	0	4,248	13,335	17,583	110	58.00
60.00	06000	LABORATORY	0	18,388	57,714	76,102	145	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,568	26,894	35,462	372	65.00
66.00	06600	PHYSICAL THERAPY	0	9,071	28,472	37,543	312	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,462	14,006	18,468	175	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,053	3,306	4,359	34	68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,528	61,294	80,822	135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,667	5,232	6,899	28	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24,244	76,095	100,339	432	90.00
90.01	09001	CLINIC - DIABETES	0	2,118	6,649	8,767	8	90.01
91.00	09100	EMERGENCY	0	19,469	61,107	80,576	1,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	476,978	1,497,120	1,974,098	8,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,801	11,931	15,732	9	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	152,127	0	152,127	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	8,438	26,484	34,922	24	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	21,979	0	21,979	78	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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	663,323	1,535,535	2,198,858	8,620	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	402,749					5.00
7.00	00700	OPERATION OF PLANT	20,947	325,047				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,383	2,083	16,478			8.00
9.00	00900	HOUSEKEEPING	6,787	4,761	0	41,497		9.00
10.00	01000	DIETARY	6,836	10,295	0	2,106	83,740	10.00
11.00	01100	CAFETERIA	889	5,408	0	1,106	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,921	14,809	0	3,029	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,422	11,714	0	2,396	0	14.00
15.00	01500	PHARMACY	12,858	3,323	0	680	0	15.00
17.00	01700	SOCIAL SERVICE	613	388	0	79	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,399	23,428	5,874	4,792	61,327	30.00
31.00	03100	INTENSIVE CARE UNIT	17,037	6,140	2,524	1,256	22,413	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,626	28,952	2,944	5,923	0	50.00
51.00	05100	RECOVERY ROOM	3,980	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,326	12,918	0	2,642	0	54.00
56.00	05600	RADIOISOTOPE	1,974	0	0	0	0	56.00
57.00	05700	CT SCAN	4,642	2,652	0	542	0	57.00
58.00	05800	MRI	2,995	2,814	0	576	0	58.00
60.00	06000	LABORATORY	34,194	12,181	0	2,492	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,896	5,676	0	1,161	0	65.00
66.00	06600	PHYSICAL THERAPY	9,174	6,009	0	1,229	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,357	2,956	0	605	0	67.00
68.00	06800	SPEECH PATHOLOGY	867	698	0	143	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,537	12,936	0	2,646	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,885	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	876	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,561	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	827	1,104	0	226	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,248	16,060	0	3,285	0	90.00
90.01	09001	CLINIC - DIABETES	919	1,403	0	287	0	90.01
91.00	09100	EMERGENCY	32,210	12,897	5,136	2,638	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	397,186	201,605	16,478	39,839	83,740	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	362	2,518	0	515	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,965	100,775	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	1,131	5,589	0	1,143	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	2,105	14,560	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	402,749	325,047	16,478	41,497	83,740	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	41,225					11.00
13.00	01300	NURSING ADMINISTRATION	3,040	134,051				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	380	0	99,127			14.00
15.00	01500	PHARMACY	1,330	0	5,787	45,037		15.00
17.00	01700	SOCIAL SERVICE	190	0	0	0	3,721	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,406	52,388	13,486	18	2,725	30.00
31.00	03100	INTENSIVE CARE UNIT	3,040	21,571	11,029	12	996	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,280	6,163	6,180	3	0	50.00
51.00	05100	RECOVERY ROOM	760	6,163	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,470	0	3,245	17	0	54.00
56.00	05600	RADIOISOTOPE	190	0	127	0	0	56.00
57.00	05700	CT SCAN	1,140	0	3,857	3	0	57.00
58.00	05800	MRI	570	0	201	0	0	58.00
60.00	06000	LABORATORY	3,610	0	1	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,900	0	11,417	8	0	65.00
66.00	06600	PHYSICAL THERAPY	1,710	0	736	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	760	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	190	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	760	3,082	2,400	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,142	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,499	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	44,957	0	73.00
76.97	07697	CARDIAC REHABILITATION	190	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,660	12,327	0	9	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,509	32,357	17,005	10	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,085	134,051	99,112	45,037	3,721	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	190	0	6	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	760	0	9	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	41,225	134,051	99,127	45,037	3,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/14/2021 11:18 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	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	351,408	0	351,408	30.00
31.00	03100	INTENSIVE CARE UNIT	125,038	0	125,038	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	246,523	0	246,523	50.00
51.00	05100	RECOVERY ROOM	11,067	0	11,067	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,810	0	117,810	54.00
56.00	05600	RADIOISOTOPE	2,337	0	2,337	56.00
57.00	05700	CT SCAN	29,581	0	29,581	57.00
58.00	05800	MRI	24,849	0	24,849	58.00
60.00	06000	LABORATORY	128,725	0	128,725	60.00
65.00	06500	RESPIRATORY THERAPY	64,892	0	64,892	65.00
66.00	06600	PHYSICAL THERAPY	56,713	0	56,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,321	0	27,321	67.00
68.00	06800	SPEECH PATHOLOGY	6,291	0	6,291	68.00
69.00	06900	ELECTROCARDIOLOGY	111,318	0	111,318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,027	0	18,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,375	0	8,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	154,518	0	154,518	73.00
76.97	07697	CARDIAC REHABILITATION	9,274	0	9,274	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	147,360	0	147,360	90.00
90.01	09001	CLINIC - DIABETES	11,384	0	11,384	90.01
91.00	09100	EMERGENCY	189,358	0	189,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,842,169	0	1,842,169	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,326	0	19,326	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	254,867	0	254,867	192.00
194.00	07950	OCCUPATIONAL HEALTH	43,005	0	43,005	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	39,491	0	39,491	194.02
194.03	07953	HOME CARE	0	0	0	194.03
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)	2,198,858	0	2,198,858	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	167,529					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		123,557				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	526	526	17,585,826			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,540	24,540	1,239,580	-15,217,414	43,789,125	5.00
7.00	00700	OPERATION OF PLANT	18,537	18,537	674,708	0	2,277,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	150,357	8.00
9.00	00900	HOUSEKEEPING	1,815	1,815	422,556	0	737,973	9.00
10.00	01000	DIETARY	3,925	3,925	373,097	0	743,320	10.00
11.00	01100	CAFETERIA	2,062	2,062	64,396	0	96,684	11.00
13.00	01300	NURSING ADMINISTRATION	5,646	5,646	1,489,448	0	2,166,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,466	4,466	60,344	0	1,241,922	14.00
15.00	01500	PHARMACY	1,267	1,267	603,912	0	1,398,067	15.00
17.00	01700	SOCIAL SERVICE	148	148	52,291	0	66,706	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,932	8,932	2,429,526	0	3,522,779	30.00
31.00	03100	INTENSIVE CARE UNIT	2,341	2,341	1,343,322	0	1,852,445	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,038	11,038	1,165,411	0	1,372,877	50.00
51.00	05100	RECOVERY ROOM	0	0	333,715	0	432,745	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,925	4,925	989,200	0	1,666,417	54.00
56.00	05600	RADIOISOTOPE	0	0	93,986	0	214,617	56.00
57.00	05700	CT SCAN	1,011	1,011	362,636	0	504,739	57.00
58.00	05800	MRI	1,073	1,073	225,151	0	325,652	58.00
60.00	06000	LABORATORY	4,644	4,644	296,159	0	3,717,946	60.00
65.00	06500	RESPIRATORY THERAPY	2,164	2,164	759,886	0	967,230	65.00
66.00	06600	PHYSICAL THERAPY	2,291	2,291	637,681	0	997,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,127	1,127	356,856	0	473,753	67.00
68.00	06800	SPEECH PATHOLOGY	266	266	69,406	0	94,282	68.00
69.00	06900	ELECTROCARDIOLOGY	4,932	4,932	276,118	0	928,184	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	204,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	95,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,910,252	73.00
76.97	07697	CARDIAC REHABILITATION	421	421	58,023	0	89,961	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,123	6,123	882,127	0	1,331,752	90.00
90.01	09001	CLINIC - DIABETES	535	535	16,642	0	99,934	90.01
91.00	09100	EMERGENCY	4,917	4,917	2,082,350	0	3,502,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,466	120,466	17,358,527	-15,217,414	43,184,207	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	960	18,713	0	39,403	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,421	0	0	0	213,653	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,131	2,131	48,740	0	122,999	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	159,846	0	228,863	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	663,323	1,535,535	4,032,243		15,217,414	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.959452	12.427746	0.229289		0.347516	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,620		402,749	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000490		0.009197	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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	123,926					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	234,920				8.00
9.00	00900	HOUSEKEEPING	1,815	0	77,345			9.00
10.00	01000	DIETARY	3,925	0	3,925	44,733		10.00
11.00	01100	CAFETERIA	2,062	0	2,062	0	217	11.00
13.00	01300	NURSING ADMINISTRATION	5,646	0	5,646	0	16	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,466	0	4,466	0	2	14.00
15.00	01500	PHARMACY	1,267	0	1,267	0	7	15.00
17.00	01700	SOCIAL SERVICE	148	0	148	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,932	83,744	8,932	32,760	39	30.00
31.00	03100	INTENSIVE CARE UNIT	2,341	35,982	2,341	11,973	16	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,038	41,973	11,038	0	12	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	4	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,925	0	4,925	0	13	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1	56.00
57.00	05700	CT SCAN	1,011	0	1,011	0	6	57.00
58.00	05800	MRI	1,073	0	1,073	0	3	58.00
60.00	06000	LABORATORY	4,644	0	4,644	0	19	60.00
65.00	06500	RESPIRATORY THERAPY	2,164	0	2,164	0	10	65.00
66.00	06600	PHYSICAL THERAPY	2,291	0	2,291	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,127	0	1,127	0	4	67.00
68.00	06800	SPEECH PATHOLOGY	266	0	266	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	4,932	0	4,932	0	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	421	0	421	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,123	0	6,123	0	14	90.00
90.01	09001	CLINIC - DIABETES	535	0	535	0	0	90.01
91.00	09100	EMERGENCY	4,917	73,221	4,917	0	29	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,863	234,920	74,254	44,733	211	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	0	960	0	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,421	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,131	0	2,131	0	1	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	0	0	4	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	3,069,140	222,272	1,039,380	1,151,587	209,060	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.765909	0.946160	13.438231	25.743567	963.410138	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	325,047	16,478	41,497	83,740	41,225	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.622912	0.070143	0.536518	1.871996	189.976959	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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:18 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	87					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,258,614				14.00
15.00	01500	PHARMACY	0	73,471	11,931,678			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	5,253		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34	171,232	4,884	3,847		30.00
31.00	03100	INTENSIVE CARE UNIT	14	140,033	3,210	1,406		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4	78,463	881	0		50.00
51.00	05100	RECOVERY ROOM	4	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,196	4,458	0		54.00
56.00	05600	RADIOISOTOPE	0	1,613	0	0		56.00
57.00	05700	CT SCAN	0	48,967	739	0		57.00
58.00	05800	MRI	0	2,550	0	0		58.00
60.00	06000	LABORATORY	0	11	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	144,958	2,133	0		65.00
66.00	06600	PHYSICAL THERAPY	0	9,344	130	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2	30,467	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	204,949	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,209	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,910,252	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8	0	2,255	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	21	215,959	2,736	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87	1,258,422	11,931,678	5,253		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	OCCUPATIONAL HEALTH	0	74	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	118	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
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)	3,149,934	1,846,057	2,046,829	96,504		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36,206.137931	1.466738	0.171546	18.371216		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	134,051	99,127	45,037	3,721		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,540.816092	0.078759	0.003775	0.708357		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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,602,079		7,602,079	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,681,982		3,681,982	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,583,008		2,583,008	0	0	50.00
51.00	05100	RECOVERY ROOM	731,810		731,810	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,507,392		2,507,392	0	0	54.00
56.00	05600	RADIOISOTOPE	292,529		292,529	0	0	56.00
57.00	05700	CT SCAN	796,497		796,497	0	0	57.00
58.00	05800	MRI	486,444		486,444	0	0	58.00
60.00	06000	LABORATORY	5,205,733		5,205,733	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,608,646	0	1,608,646	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,454,094	0	1,454,094	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	685,300	0	685,300	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	138,173	0	138,173	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,560,118		1,560,118	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	576,778		576,778	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	267,943		267,943	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,092,399		18,092,399	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	138,270		138,270	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,332,005		2,332,005	0	0	90.00
90.01	09001	CLINIC - DIABETES	155,102		155,102	0	0	90.01
91.00	09100	EMERGENCY	6,081,940		6,081,940	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,863,313		1,863,313		0	92.00
200.00		Subtotal (see instructions)	58,841,555	0	58,841,555	0	0	200.00
201.00		Less Observation Beds	1,863,313		1,863,313		0	201.00
202.00		Total (see instructions)	56,978,242	0	56,978,242	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	8,031,783		8,031,783			30.00
31.00	03100	INTENSIVE CARE UNIT	9,399,199		9,399,199			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,924,223	18,650,186	21,574,409	0.119726	0.000000	50.00
51.00	05100	RECOVERY ROOM	158,600	4,717,496	4,876,096	0.150081	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	744,896	11,646,391	12,391,287	0.202351	0.000000	54.00
56.00	05600	RADIOISOTOPE	164,845	2,546,721	2,711,566	0.107882	0.000000	56.00
57.00	05700	CT SCAN	644,194	7,475,281	8,119,475	0.098097	0.000000	57.00
58.00	05800	MRI	164,954	2,244,049	2,409,003	0.201928	0.000000	58.00
60.00	06000	LABORATORY	3,627,528	15,370,383	18,997,911	0.274016	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,810,798	2,969,951	5,780,749	0.278276	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	414,919	2,228,131	2,643,050	0.550158	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	433,680	866,656	1,300,336	0.527018	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	67,755	239,190	306,945	0.450156	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	998,587	8,020,029	9,018,616	0.172989	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	743,100	1,570,172	2,313,272	0.249334	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,453	837,316	882,769	0.303526	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,483,897	61,774,104	71,258,001	0.253900	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,174,169	1,174,169	0.117760	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,098	12,790,702	12,839,800	0.181623	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	30,597	30,597	5.069190	0.000000	90.01
91.00	09100	EMERGENCY	1,477,595	35,728,489	37,206,084	0.163466	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	17,927	7,910,244	7,928,171	0.235024	0.000000	92.00
200.00		Subtotal (see instructions)	42,403,031	198,790,257	241,193,288			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,403,031	198,790,257	241,193,288			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/14/2021 11:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,602,079		7,602,079	0	7,602,079	30.00
31.00	03100	INTENSIVE CARE UNIT	3,681,982		3,681,982	0	3,681,982	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,583,008		2,583,008	0	2,583,008	50.00
51.00	05100	RECOVERY ROOM	731,810		731,810	0	731,810	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,507,392		2,507,392	0	2,507,392	54.00
56.00	05600	RADIOISOTOPE	292,529		292,529	0	292,529	56.00
57.00	05700	CT SCAN	796,497		796,497	0	796,497	57.00
58.00	05800	MRI	486,444		486,444	0	486,444	58.00
60.00	06000	LABORATORY	5,205,733		5,205,733	0	5,205,733	60.00
65.00	06500	RESPIRATORY THERAPY	1,608,646	0	1,608,646	0	1,608,646	65.00
66.00	06600	PHYSICAL THERAPY	1,454,094	0	1,454,094	0	1,454,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	685,300	0	685,300	0	685,300	67.00
68.00	06800	SPEECH PATHOLOGY	138,173	0	138,173	0	138,173	68.00
69.00	06900	ELECTROCARDIOLOGY	1,560,118		1,560,118	0	1,560,118	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	576,778		576,778	0	576,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	267,943		267,943	0	267,943	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,092,399		18,092,399	0	18,092,399	73.00
76.97	07697	CARDIAC REHABILITATION	138,270		138,270	0	138,270	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,332,005		2,332,005	0	2,332,005	90.00
90.01	09001	CLINIC - DIABETES	155,102		155,102	0	155,102	90.01
91.00	09100	EMERGENCY	6,081,940		6,081,940	0	6,081,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,863,313		1,863,313		1,863,313	92.00
200.00		Subtotal (see instructions)	58,841,555	0	58,841,555	0	58,841,555	200.00
201.00		Less Observation Beds	1,863,313		1,863,313		1,863,313	201.00
202.00		Total (see instructions)	56,978,242	0	56,978,242	0	56,978,242	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	8,031,783		8,031,783			30.00
31.00	03100	INTENSIVE CARE UNIT	9,399,199		9,399,199			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,924,223	18,650,186	21,574,409	0.119726	0.000000	50.00
51.00	05100	RECOVERY ROOM	158,600	4,717,496	4,876,096	0.150081	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	744,896	11,646,391	12,391,287	0.202351	0.000000	54.00
56.00	05600	RADIOISOTOPE	164,845	2,546,721	2,711,566	0.107882	0.000000	56.00
57.00	05700	CT SCAN	644,194	7,475,281	8,119,475	0.098097	0.000000	57.00
58.00	05800	MRI	164,954	2,244,049	2,409,003	0.201928	0.000000	58.00
60.00	06000	LABORATORY	3,627,528	15,370,383	18,997,911	0.274016	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,810,798	2,969,951	5,780,749	0.278276	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	414,919	2,228,131	2,643,050	0.550158	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	433,680	866,656	1,300,336	0.527018	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	67,755	239,190	306,945	0.450156	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	998,587	8,020,029	9,018,616	0.172989	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	743,100	1,570,172	2,313,272	0.249334	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,453	837,316	882,769	0.303526	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,483,897	61,774,104	71,258,001	0.253900	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,174,169	1,174,169	0.117760	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,098	12,790,702	12,839,800	0.181623	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	30,597	30,597	5.069190	0.000000	90.01
91.00	09100	EMERGENCY	1,477,595	35,728,489	37,206,084	0.163466	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	17,927	7,910,244	7,928,171	0.235024	0.000000	92.00
200.00		Subtotal (see instructions)	42,403,031	198,790,257	241,193,288			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,403,031	198,790,257	241,193,288			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/14/2021 11:18 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	246,523	21,574,409	0.011427	886,900	10,135	50.00
51.00	05100	RECOVERY ROOM	11,067	4,876,096	0.002270	37,088	84	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,810	12,391,287	0.009507	333,765	3,173	54.00
56.00	05600	RADIOISOTOPE	2,337	2,711,566	0.000862	106,732	92	56.00
57.00	05700	CT SCAN	29,581	8,119,475	0.003643	199,001	725	57.00
58.00	05800	MRI	24,849	2,409,003	0.010315	65,770	678	58.00
60.00	06000	LABORATORY	128,725	18,997,911	0.006776	1,690,389	11,454	60.00
65.00	06500	RESPIRATORY THERAPY	64,892	5,780,749	0.011226	1,335,131	14,988	65.00
66.00	06600	PHYSICAL THERAPY	56,713	2,643,050	0.021457	218,028	4,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,321	1,300,336	0.021011	222,982	4,685	67.00
68.00	06800	SPEECH PATHOLOGY	6,291	306,945	0.020496	34,084	699	68.00
69.00	06900	ELECTROCARDIOLOGY	111,318	9,018,616	0.012343	477,210	5,890	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,027	2,313,272	0.007793	308,230	2,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,375	882,769	0.009487	1,627	15	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	154,518	71,258,001	0.002168	4,124,221	8,941	73.00
76.97	07697	CARDIAC REHABILITATION	9,274	1,174,169	0.007898	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	147,360	12,839,800	0.011477	1,241	14	90.00
90.01	09001	CLINIC - DIABETES	11,384	30,597	0.372063	0	0	90.01
91.00	09100	EMERGENCY	189,358	37,206,084	0.005089	74,707	380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	86,132	7,928,171	0.010864	4,556	49	92.00
200.00		Total (lines 50 through 199)	1,451,855	223,762,306		10,121,662	69,082	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328

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

Worksheet D Part IV
Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	21,574,409	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,876,096	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,391,287	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,711,566	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,119,475	0.000000	57.00
58.00	05800	MRI	0	0	0	2,409,003	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	18,997,911	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,780,749	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,643,050	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,300,336	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	306,945	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,018,616	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,313,272	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	882,769	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,258,001	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,174,169	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,839,800	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	30,597	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	37,206,084	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,928,171	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	223,762,306		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	886,900	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	37,088	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	333,765	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	106,732	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	199,001	0	0	0	57.00
58.00	05800	MRI	0.000000	65,770	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,690,389	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,335,131	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	218,028	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	222,982	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	34,084	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	477,210	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	308,230	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,627	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,124,221	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,241	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	74,707	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	4,556	0	0	0	92.00
200.00		Total (lines 50 through 199)		10,121,662	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119726	0	4,245,722	0	0	50.00
51.00	05100	RECOVERY ROOM	0.150081	0	1,122,745	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202351	0	2,897,959	0	0	54.00
56.00	05600	RADIOISOTOPE	0.107882	0	878,056	0	0	56.00
57.00	05700	CT SCAN	0.098097	0	2,657,283	0	0	57.00
58.00	05800	MRI	0.201928	0	708,047	0	0	58.00
60.00	06000	LABORATORY	0.274016	0	4,635,466	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.278276	0	1,128,576	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.550158	0	659,205	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.527018	0	212,035	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.450156	0	34,782	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172989	0	2,475,731	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249334	0	334,773	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303526	0	118,317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253900	0	27,982,956	4,940	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.117760	0	552,143	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.181623	0	5,403,999	0	0	90.00
90.01	09001	CLINIC - DIABETES	5.069190	0	4,448	0	0	90.01
91.00	09100	EMERGENCY	0.163466	0	10,420,838	5,692	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.235024	0	3,220,546	0	0	92.00
200.00		Subtotal (see instructions)		0	69,693,627	10,632	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	69,693,627	10,632	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	508,323	0	50.00
51.00	05100	RECOVERY ROOM	168,503	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,405	0	54.00
56.00	05600	RADIOISOTOPE	94,726	0	56.00
57.00	05700	CT SCAN	260,671	0	57.00
58.00	05800	MRI	142,975	0	58.00
60.00	06000	LABORATORY	1,270,192	0	60.00
65.00	06500	RESPIRATORY THERAPY	314,056	0	65.00
66.00	06600	PHYSICAL THERAPY	362,667	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,746	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,657	0	68.00
69.00	06900	ELECTROCARDIOLOGY	428,274	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,470	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,912	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,104,873	1,254	73.00
76.97	07697	CARDIAC REHABILITATION	65,020	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	981,491	0	90.00
90.01	09001	CLINIC - DIABETES	22,548	0	90.01
91.00	09100	EMERGENCY	1,703,453	930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	756,906	0	92.00
200.00		Subtotal (see instructions)	15,017,868	2,184	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	15,017,868	2,184	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119726	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.150081	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202351	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.107882	0	0	0	0	56.00
57.00	05700	CT SCAN	0.098097	0	0	0	0	57.00
58.00	05800	MRI	0.201928	0	0	0	0	58.00
60.00	06000	LABORATORY	0.274016	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.278276	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.550158	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.527018	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.450156	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172989	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249334	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303526	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253900	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.117760	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.181623	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	5.069190	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.163466	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.235024	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	90.01
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)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,180	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,111	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)	3,847	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	42	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	27	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,928	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)	42	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	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)	7,602,079	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)	5,858	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)	67,772	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,534,307	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)	7,534,307	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)	1,474.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,842,142	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)	2,842,142	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,681,982	1,406	2,618.76	662	1,733,619	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,531,689	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,107,450	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)	61,914	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)	61,914	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,264	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,474.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,863,313	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/14/2021 11:18 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	351,408	7,602,079	0.046225	1,863,313	86,132	90.00
91.00	Nursing School cost	0	7,602,079	0.000000	1,863,313	0	91.00
92.00	Allied health cost	0	7,602,079	0.000000	1,863,313	0	92.00
93.00	All other Medical Education	0	7,602,079	0.000000	1,863,313	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:18 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)	5,180	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,111	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)	3,847	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	42	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	27	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)	95	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	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)	7,602,079	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)	5,858	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)	67,772	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,534,307	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)	7,534,307	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)	1,474.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	140,043	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)	140,043	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:18 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,681,982	1,406	2,618.76	49	128,319	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)	148,500	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	416,862	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,264	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,474.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,863,313	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:18 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	351,408	7,602,079	0.046225	1,863,313	86,132	90.00
91.00	Nursing School cost	0	7,602,079	0.000000	1,863,313	0	91.00
92.00	Allied health cost	0	7,602,079	0.000000	1,863,313	0	92.00
93.00	All other Medical Education	0	7,602,079	0.000000	1,863,313	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,020,057		30.00
31.00	03100	INTENSIVE CARE UNIT		4,165,179		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119726	886,900	106,185	50.00
51.00	05100	RECOVERY ROOM	0.150081	37,088	5,566	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202351	333,765	67,538	54.00
56.00	05600	RADIOISOTOPE	0.107882	106,732	11,514	56.00
57.00	05700	CT SCAN	0.098097	199,001	19,521	57.00
58.00	05800	MRI	0.201928	65,770	13,281	58.00
60.00	06000	LABORATORY	0.274016	1,690,389	463,194	60.00
65.00	06500	RESPIRATORY THERAPY	0.278276	1,335,131	371,535	65.00
66.00	06600	PHYSICAL THERAPY	0.550158	218,028	119,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.527018	222,982	117,516	67.00
68.00	06800	SPEECH PATHOLOGY	0.450156	34,084	15,343	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172989	477,210	82,552	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249334	308,230	76,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303526	1,627	494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253900	4,124,221	1,047,140	73.00
76.97	07697	CARDIAC REHABILITATION	0.117760	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.181623	1,241	225	90.00
90.01	09001	CLINIC - DIABETES	5.069190	0	0	90.01
91.00	09100	EMERGENCY	0.163466	74,707	12,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.235024	4,556	1,071	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,121,662	2,531,689	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)		10,121,662		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119726	0	0	50.00
51.00	05100	RECOVERY ROOM	0.150081	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202351	744	151	54.00
56.00	05600	RADIOISOTOPE	0.107882	0	0	56.00
57.00	05700	CT SCAN	0.098097	0	0	57.00
58.00	05800	MRI	0.201928	0	0	58.00
60.00	06000	LABORATORY	0.274016	3,572	979	60.00
65.00	06500	RESPIRATORY THERAPY	0.278276	1,105	307	65.00
66.00	06600	PHYSICAL THERAPY	0.550158	11,773	6,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.527018	23,247	12,252	67.00
68.00	06800	SPEECH PATHOLOGY	0.450156	2,958	1,332	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172989	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249334	675	168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253900	12,220	3,103	73.00
76.97	07697	CARDIAC REHABILITATION	0.117760	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.181623	0	0	90.00
90.01	09001	CLINIC - DIABETES	5.069190	0	0	90.01
91.00	09100	EMERGENCY	0.163466	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.235024	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		56,294	24,769	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)		56,294		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/14/2021 11:18 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		190,275		30.00
31.00	03100	INTENSIVE CARE UNIT		270,168		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119726	12,799	1,532	50.00
51.00	05100	RECOVERY ROOM	0.150081	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202351	26,909	5,445	54.00
56.00	05600	RADIOISOTOPE	0.107882	7,347	793	56.00
57.00	05700	CT SCAN	0.098097	23,029	2,259	57.00
58.00	05800	MRI	0.201928	4,072	822	58.00
60.00	06000	LABORATORY	0.274016	95,246	26,099	60.00
65.00	06500	RESPIRATORY THERAPY	0.278276	92,880	25,846	65.00
66.00	06600	PHYSICAL THERAPY	0.550158	5,687	3,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.527018	6,839	3,604	67.00
68.00	06800	SPEECH PATHOLOGY	0.450156	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172989	22,774	3,940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249334	16,180	4,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253900	224,807	57,078	73.00
76.97	07697	CARDIAC REHABILITATION	0.117760	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.181623	0	0	90.00
90.01	09001	CLINIC - DIABETES	5.069190	0	0	90.01
91.00	09100	EMERGENCY	0.163466	85,149	13,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.235024	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		623,718	148,500	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)		623,718		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1328 Component CCN: 15-Z328	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/14/2021 11:18 am
	Title XIX	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119726	0	0	50.00
51.00	05100	RECOVERY ROOM	0.150081	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202351	0	0	54.00
56.00	05600	RADIOISOTOPE	0.107882	0	0	56.00
57.00	05700	CT SCAN	0.098097	0	0	57.00
58.00	05800	MRI	0.201928	0	0	58.00
60.00	06000	LABORATORY	0.274016	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.278276	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.550158	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.527018	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.450156	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172989	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249334	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253900	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.117760	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.181623	0	0	90.00
90.01	09001	CLINIC - DIABETES	5.069190	0	0	90.01
91.00	09100	EMERGENCY	0.163466	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.235024	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,020,052	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	15,020,052	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	15,170,253	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	91,269	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	12,730,486	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,348,498	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,348,498	30.00
31.00	Primary payer payments	542	31.00
32.00	Subtotal (line 30 minus line 31)	2,347,956	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)	435,536	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	283,098	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-16,706	36.00
37.00	Subtotal (see instructions)	2,631,054	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,631,054	40.00
40.01	Sequestration adjustment (see instructions)	17,365	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,191,111	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)	-577,422	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	773,077	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: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Prepared: 7/14/2021 11:18 am
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,102,584		3,191,111	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,102,584		3,191,111	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		355,909		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		577,422	6.02
7.00	Total Medicare program liability (see instructions)		6,458,493		2,613,689	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		85,889		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		85,889		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,588		0	6.02
7.00	Total Medicare program liability (see instructions)		83,301		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/14/2021 11:18 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	62,533	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	25,017	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	42	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	87,550	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	87,550	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	87,550	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,696	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	83,854	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	83,854	0	19.00
19.01	Sequestration adjustment (see instructions)	553	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	85,889	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-2,588	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	4,461	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/14/2021 11:18 am

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part V | Date/Time Prepared: 7/14/2021 11:18 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	7,107,450	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	7,107,450	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	7,178,525	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	7,178,525	19.00
20.00	Deductibles (exclude professional component)	710,732	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	6,467,793	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	6,467,793	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,706	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,609	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,926	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	6,501,402	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	6,501,402	30.00
30.01	Sequestration adjustment (see instructions)	42,909	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	6,102,584	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	355,909	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	365,907	34.00

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

Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/14/2021 11:18 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	82,385,089	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	10,298,049	0	0	0	4.00
5.00	Other receivable	-4,741,170	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,699,878	0	0	0	7.00
8.00	Prepaid expenses	167,330	0	0	0	8.00
9.00	Other current assets	205,546	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	90,014,722	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	931,334	0	0	0	12.00
13.00	Land improvements	1,119,735	0	0	0	13.00
14.00	Accumulated depreciation	-1,073,695	0	0	0	14.00
15.00	Buildings	19,235,457	0	0	0	15.00
16.00	Accumulated depreciation	-13,086,107	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	242,498	0	0	0	21.00
22.00	Accumulated depreciation	-213,076	0	0	0	22.00
23.00	Major movable equipment	15,150,854	0	0	0	23.00
24.00	Accumulated depreciation	-11,300,996	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	669,179	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,675,183	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,263,774	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,263,774	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,953,679	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,599,033	0	0	0	37.00
38.00	Salaries, wages, and fees payable	988,701	0	0	0	38.00
39.00	Payroll taxes payable	1,139,790	0	0	0	39.00
40.00	Notes and loans payable (short term)	58,709	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	10,878,901				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,546,997	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,212,131	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	298,728	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	298,728	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,510,859	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	88,442,820				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)	88,442,820	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,953,679	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/14/2021 11:18 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		67,467,515		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		20,975,304				2.00
3.00	Total (sum of line 1 and line 2)		88,442,819		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		88,442,820		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)		88,442,820		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	ROUNDING		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: 15-1328 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/14/2021 11:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,972,837		7,972,837	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	58,946		58,946	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,031,783		8,031,783	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,399,199		9,399,199	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)	9,399,199		9,399,199	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,430,982		17,430,982	17.00
18.00	Ancillary services	23,427,429	142,330,226	165,757,655	18.00
19.00	Outpatient services	1,544,620	56,460,032	58,004,652	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	1,498,469	1,498,469	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,403,031	200,288,727	242,691,758	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,006,997		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)		63,006,997		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 7/14/2021 11:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	242,691,758	1.00
2.00	Less contractual allowances and discounts on patients' accounts	161,466,096	2.00
3.00	Net patient revenues (line 1 minus line 2)	81,225,662	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,006,997	4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,218,665	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	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	MISCELLANEOUS INCOME	2,320,015	24.00
24.50	COVID-19 PHE Funding	436,624	24.50
25.00	Total other income (sum of lines 6-24)	2,756,639	25.00
26.00	Total (line 5 plus line 25)	20,975,304	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)	20,975,304	29.00