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:15-1312	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/13/2021 4:34 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/13/2021 Time: 4:34 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTIONS, 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 IU HEALTH WHITE HOSPITAL (15-1312) 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) TODD WILLIAMS
Officer or Administrator of Provider(s)

CHIEF 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	-123,083	-65,271	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	-56,174	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-179,257	-65,271	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street:720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code:47960	County: WHITE	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	IU HEALTH WHITE HOSPITAL	151312	99915	1	07/01/1966	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 WHITE HOSPITAL	15Z312	99915		02/16/1990	N	O	N	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/13/2021 4:34 pm

		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.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

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

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

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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	Y	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:	39,603	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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

		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	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:15-1312	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/13/2021 4:34 pm

		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	152	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/13/2021 4:34 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/13/2021 4:34 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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.					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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:15-1312	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/13/2021 4:34 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVERNMENT PROGRAMS 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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	45,936.00	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)		25	9,150	45,936.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	45,936.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,026	17	1,914			1.00
2.00	HMO and other (see instructions)	363	138				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	461	0	461			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	623			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,487	17	2,998			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)	1,487	17	2,998	0.00	143.42	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			26			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	143.42	27.00
28.00	Observation Bed Days		15	551			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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	290	5	578	1.00
2.00	HMO and other (see instructions)			108	49		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	290	5	578	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/13/2021 4:34 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.331401	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,824,277	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	14,732,609	6.00
7.00	Medicaid cost (line 1 times line 6)	4,882,401	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)	3,058,124	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)	2,702	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	56,471	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	18,715	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)	16,013	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)	8,374,137	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)	2,082,698	62,133	2,144,831	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	690,208	62,133	752,341	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)	690,208	62,133	752,341	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)	2,862,091	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	259,055	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	398,546	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,463,545	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	955,912	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,708,253	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,782,390	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,715,664	1,715,664	-1,704,087	11,577	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,503,785	2,503,785	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	224,885	224,885	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,290	50,068	53,358	1,763,435	1,816,793	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	843,013	7,378,917	8,221,930	-517,608	7,704,322	5.00
7.00	00700	OPERATION OF PLANT	450,465	1,873,361	2,323,826	-1,837,266	486,560	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	1,619,623	1,619,623	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	228,803	228,803	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	61,244	61,244	8.00
9.00	00900	HOUSEKEEPING	338,027	273,476	611,503	-199,079	412,424	9.00
10.00	01000	DIETARY	459,541	363,142	822,683	-272,036	550,647	10.00
11.00	01100	CAFETERIA	0	0	0	127,134	127,134	11.00
13.00	01300	NURSING ADMINISTRATION	719,802	249,634	969,436	34,967	1,004,403	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,105	6,105	466,572	472,677	14.00
15.00	01500	PHARMACY	392,195	3,795,735	4,187,930	-3,485,595	702,335	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,517,264	869,135	2,386,399	-517,204	1,869,195	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	455,897	776,902	1,232,799	-188,376	1,044,423	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,157	348,923	652,080	-244,700	407,380	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	68,154	92,251	160,405	-30,758	129,647	55.00
56.00	05600	RADIOISOTOPE	132,218	54,443	186,661	-45,302	141,359	56.00
57.00	05700	CT SCAN	400,309	253,325	653,634	-221,500	432,134	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	141,730	67,381	209,111	-54,689	154,422	58.00
60.00	06000	LABORATORY	0	1,447,376	1,447,376	0	1,447,376	60.00
66.00	06600	PHYSICAL THERAPY	422,654	112,491	535,145	-82,260	452,885	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,136	45,154	209,290	-32,870	176,420	67.00
68.00	06800	SPEECH PATHOLOGY	98,095	24,415	122,510	-16,996	105,514	68.00
69.00	06900	ELECTROCARDIOLOGY	130,357	43,571	173,928	-28,772	145,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50,401	50,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,405	7,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	452,111	452,111	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	3,042,618	3,042,618	73.01
76.00	03160	CARDIOPULMONARY	461,104	248,485	709,589	-163,008	546,581	76.00
76.97	07697	CARDIAC REHABILITATION	64,415	8,792	73,207	-3,731	69,476	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	143,992	72,869	216,861	-54,043	162,818	90.00
91.00	09100	EMERGENCY	1,214,204	1,804,382	3,018,586	-414,269	2,604,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,924,019	21,975,997	30,900,016	468,834	31,368,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	46,461	28,432	74,893	-15,146	59,747	192.00
192.02	19202	MOB	0	453,688	453,688	-453,688	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	8,970,480	22,458,117	31,428,597	0	31,428,597	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	23,335	34,912		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	286,522	2,790,307		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	293,636	518,521		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	53,361	1,870,154		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	319,700	8,024,022		5.00
7.00	00700	OPERATION OF PLANT	0	486,560		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	49,557	1,669,180		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	228,803		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,244		8.00
9.00	00900	HOUSEKEEPING	0	412,424		9.00
10.00	01000	DIETARY	-115,361	435,286		10.00
11.00	01100	CAFETERIA	-37,546	89,588		11.00
13.00	01300	NURSING ADMINISTRATION	50,373	1,054,776		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-16,479	456,198		14.00
15.00	01500	PHARMACY	323,965	1,026,300		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	17,760	1,886,955		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-211,973	832,450		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-460	406,920		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	129,647		55.00
56.00	05600	RADIOISOTOPE	0	141,359		56.00
57.00	05700	CT SCAN	0	432,134		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	154,422		58.00
60.00	06000	LABORATORY	0	1,447,376		60.00
66.00	06600	PHYSICAL THERAPY	0	452,885		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	176,420		67.00
68.00	06800	SPEECH PATHOLOGY	0	105,514		68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,156		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	50,401		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,405		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	452,111		73.00
73.01	07301	ONCOLOGY DRUGS	0	3,042,618		73.01
76.00	03160	CARDIOPULMONARY	129,711	676,292		76.00
76.97	07697	CARDIAC REHABILITATION	0	69,476		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-30	162,788		90.00
91.00	09100	EMERGENCY	18,069	2,622,386		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,184,140	32,552,990		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,747		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,184,140	32,612,737		200.00

RECLASSIFICATIONS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/13/2021 4:34 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	81,006	46,128		1.00
	0		81,006	46,128		
	B - DRUGS EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	452,111		1.00
2.00	ONCOLOGY DRUGS	73.01	0	3,042,618		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	3,494,729		
	C - MEDICAL SUPPLIES AND REBATES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	468,589		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	50,401		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,405		3.00
4.00	NURSING ADMINISTRATION	13.00	0	3,409		4.00
5.00	RADIOLOGY-THERAPEUTIC	55.00	0	74		5.00
6.00	SPEECH PATHOLOGY	68.00	0	7		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
	0		0	529,885		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	61,244		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	61,244		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,484,382		1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	215,285		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	0		0	1,699,667		

RECLASSIFICATIONS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/13/2021 4:34 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	F - OTHER CAPITAL EXPENSES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,808	1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	997,256	2.00
3.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	24,955	3.00
4.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	9,600	4.00
	0		0	1,034,619	
	G - OPERATION OF PLANT				
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	1,619,623	1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	228,803	2.00
	0		0	1,848,426	
	H - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,685,255	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
	0		0	1,685,255	
	I - HOUSEKEEPING SUPPLIES				
1.00	HOUSEKEEPING	9.00	0	10,265	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	0		0	10,265	
	J - NON-CAPITAL EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	155	1.00
	0		0	155	
	K - CNO				
1.00	NURSING ADMINISTRATION	13.00	127,456	0	1.00
	TOTALS		127,456	0	
	L - ACCRUED PTO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	82,669	0	1.00
	TOTALS		82,669	0	
	M - THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	0	399	1.00
	TOTALS		0	399	
500.00	Grand Total: Increases		291,131	10,410,772	500.00

RECLASSIFICATIONS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/13/2021 4:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	81,006	46,128	0		1.00
	0		81,006	46,128			
	B - DRUGS EXPENSE						
1.00	PHARMACY	15.00	0	3,395,492	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,717	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,217	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,994	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	14,346	0		5.00
6.00	OPERATING ROOM	50.00	0	3,091	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,240	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	13,055	0		8.00
9.00	RADIOISOTOPE	56.00	0	652	0		9.00
10.00	CT SCAN	57.00	0	18,993	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,514	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	87	0		12.00
13.00	CARDIOPULMONARY	76.00	0	6,344	0		13.00
14.00	CLINIC	90.00	0	10,583	0		14.00
15.00	EMERGENCY	91.00	0	19,404	0		15.00
	0		0	3,494,729			
	C - MEDICAL SUPPLIES AND REBATES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	358	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	26,356	0		2.00
3.00	OPERATION OF PLANT	7.00	0	29,948	0		3.00
4.00	HOUSEKEEPING	9.00	0	28,560	0		4.00
5.00	DIETARY	10.00	0	1,106	0		5.00
6.00	PHARMACY	15.00	0	19,563	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	108,466	0		7.00
8.00	OPERATING ROOM	50.00	0	42,351	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,169	0		9.00
10.00	RADIOISOTOPE	56.00	0	6,147	0		10.00
11.00	CT SCAN	57.00	0	45,638	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	12,535	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	7,365	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	483	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	6,835	0		15.00
16.00	CARDIOPULMONARY	76.00	0	33,217	0		16.00
17.00	CARDIAC REHABILITATION	76.97	0	1,063	0		17.00
18.00	CLINIC	90.00	0	12,089	0		18.00
19.00	EMERGENCY	91.00	0	143,281	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,355	0		20.00
	0		0	529,885			
	D - LAUNDRY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42	0		1.00
2.00	HOUSEKEEPING	9.00	0	56,373	0		2.00
3.00	DIETARY	10.00	0	4,829	0		3.00
	0		0	61,244			
	E - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	706,676	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,414	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	177,612	0		3.00
4.00	OPERATION OF PLANT	7.00	0	67,577	0		4.00
5.00	DIETARY	10.00	0	26,899	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	380	0		6.00
7.00	PHARMACY	15.00	0	27,020	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	72,589	0		8.00
9.00	OPERATING ROOM	50.00	0	66,277	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	175,423	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,369	0		11.00
12.00	RADIOISOTOPE	56.00	0	8,205	0		12.00
13.00	CT SCAN	57.00	0	86,549	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	7,630	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	3,890	0		15.00
16.00	CARDIOPULMONARY	76.00	0	6,191	0		16.00
17.00	EMERGENCY	91.00	0	45,241	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,440	0		18.00
19.00	MOB	192.02	0	215,285	0		19.00
	0		0	1,699,667			

RECLASSIFICATIONS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/13/2021 4:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	F - OTHER CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	2,808	10		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	997,256	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	24,955	12		3.00
4.00	MOB	192.02	0	9,600	13		4.00
	0		0	1,034,619			
	G - OPERATION OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	1,619,623	0		1.00
2.00	MOB	192.02	0	228,803	0		2.00
	0		0	1,848,426			
	H - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,640	0		1.00
2.00	OPERATION OF PLANT	7.00	0	120,118	0		2.00
3.00	HOUSEKEEPING	9.00	0	124,411	0		3.00
4.00	DIETARY	10.00	0	104,588	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	95,518	0		5.00
6.00	PHARMACY	15.00	0	43,223	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	321,609	0		7.00
8.00	OPERATING ROOM	50.00	0	76,596	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,795	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,408	0		10.00
11.00	RADIOISOTOPE	56.00	0	30,263	0		11.00
12.00	CT SCAN	57.00	0	70,320	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	31,010	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	74,496	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	32,786	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	17,003	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	17,960	0		17.00
18.00	CARDIOPULMONARY	76.00	0	117,255	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	2,668	0		19.00
20.00	CLINIC	90.00	0	31,105	0		20.00
21.00	EMERGENCY	91.00	0	206,324	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,159	0		22.00
	0		0	1,685,255			
	I - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,816	0		1.00
2.00	DIETARY	10.00	0	7,480	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	23	0		3.00
4.00	PHARMACY	15.00	0	297	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	194	0		5.00
6.00	OPERATING ROOM	50.00	0	61	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73	0		7.00
8.00	RADIOISOTOPE	56.00	0	35	0		8.00
9.00	CARDIOPULMONARY	76.00	0	1	0		9.00
10.00	CLINIC	90.00	0	266	0		10.00
11.00	EMERGENCY	91.00	0	19	0		11.00
	0		0	10,265			
	J - NON-CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	155	12		1.00
	0		0	155			
	K - CNO						
1.00	ADMINISTRATIVE & GENERAL	5.00	127,456	0	0		1.00
	TOTALS		127,456	0			
	L - ACCRUED PTO						
1.00	ADMINISTRATIVE & GENERAL	5.00	82,669	0	0		1.00
	TOTALS		82,669	0			
	M - THERAPY						
1.00	PHYSICAL THERAPY	66.00	0	399	0		1.00
	TOTALS		0	399			
500.00	Grand Total: Decreases		291,131	10,410,772			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0	0	0	0	1.00
2.00	Land Improvements	813,560	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	38,459,462	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,991,171	1,986,795	0	1,986,795	233,605	6.00
7.00	HIT designated Assets	15,000	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,233,763	1,986,795	0	1,986,795	233,605	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,233,763	1,986,795	0	1,986,795	233,605	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	813,560	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	38,459,462	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,744,361	2,328,624	6.00
7.00	HIT designated Assets	15,000	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	48,986,953	2,343,624	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	48,986,953	2,343,624	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/13/2021 4:34 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	718,385	0	997,256	23	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	718,385	0	997,256	23	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	1,715,664				1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0				1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0				1.02
3.00	Total (sum of lines 1-2)	0	1,715,664				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III | Date/Time Prepared: 7/13/2021 4:34 pm

	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	1,768,130	0	1,768,130	0.036094	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	32,283,620	0	32,283,620	0.659025	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	14,935,203	0	14,935,203	0.304881	0	1.02
3.00	Total (sum of lines 1-2)	48,986,953	0	48,986,953	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	35,044	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,767,318	-2,808	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	508,921	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,311,283	-2,808	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	-132	0	0	34,912	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,000,842	24,955	0	0	2,790,307	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	9,600	0	518,521	1.02
3.00	Total (sum of lines 1-2)	1,000,842	24,823	9,600	0	3,343,740	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/13/2021 4:34 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	B	-316,006	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-352,146			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	4,734,069			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-37,546	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	*** Cost Center Deleted ***	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	A	23,335	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	185,408	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	293,636	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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

ADJUSTMENTS TO EXPENSES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/13/2021 4:34 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	0	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	32.00
33.00	EMPLOYEE BENEFITS	A	-1,685,376	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.01
33.02	MEDICAID HAF FEES	A	-1,450,597	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-3,535	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-201	DIETARY	10.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-16,452	CENTRAL SERVICES & SUPPLY	14.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-8,694	PHARMACY	15.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-460	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	WIC PROGRAM COSTS	A	-206,699	DIETARY	10.00	0	33.08
33.09	WIC PROGRAM BENEFIT COSTS	A	-36,509	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	CONTRIBUTION EXPENSE	A	-35,463	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	TELEPHONE EXPENSE	A	-27	CENTRAL SERVICES & SUPPLY	14.00	0	33.11
33.12	TELEPHONE EXPENSE	A	-30	CLINIC	90.00	0	33.12
33.13	TELEPHONE EXPENSE	A	-95	CARDIOPULMONARY	76.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,184,140				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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/13/2021 4:34 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1,316,848	997,256	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,775,246	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5,437,912	4,530,744	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	POOLED CAPITAL - H.O.	247,441	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,427,984	773,298	4.00
4.01	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	102,549	52,992	4.01
4.02	10.00	DIETARY	RELATED PARTY	91,539	0	4.02
4.03	13.00	NURSING ADMINISTRATION	RELATED PARTY	50,373	0	4.03
4.04	15.00	PHARMACY	RELATED PARTY	548,945	216,286	4.04
4.05	30.00	ADULTS & PEDIATRICS	RELATED PARTY	208,354	84,011	4.05
4.06	50.00	OPERATING ROOM	RELATED PARTY	286,638	253,048	4.06
4.07	76.00	CARDIOPULMONARY	RELATED PARTY	166,367	36,561	4.07
4.08	91.00	EMERGENCY	RELATED PARTY	137,778	119,709	4.08
4.09	1.01	CAP REL COSTS-BLDG & FIXT -	SHARED EMPLOYEES	-2,808	-2,808	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	164	164	4.10
4.11	7.01	OPERATION OF PLANT - HOSPITA	SHARED EMPLOYEES	42,854	42,854	4.11
4.12	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	106,583	106,583	4.12
4.13	50.00	OPERATING ROOM	SHARED EMPLOYEES	245,563	245,563	4.13
4.14	60.00	LABORATORY	SHARED EMPLOYEES	1,402,960	1,402,960	4.14
4.15	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	106,912	106,912	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,700,202	8,966,133	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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 tit XVIII.

(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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/13/2021 4:34 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	319,592	11		1.00
2.00	1,775,246	0		2.00
3.00	907,168	0		3.00
3.01	247,441	0		3.01
4.00	654,686	0		4.00
4.01	49,557	0		4.01
4.02	91,539	0		4.02
4.03	50,373	0		4.03
4.04	332,659	0		4.04
4.05	124,343	0		4.05
4.06	33,590	0		4.06
4.07	129,806	0		4.07
4.08	18,069	0		4.08
4.09	0	10		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
5.00	4,734,069			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 tit XVIII.

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/13/2021 4:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	106,583	106,583	0	0	0	1.00
2.00	50.00	OPERATING ROOM	245,563	245,563	0	0	0	2.00
3.00	91.00	EMERGENCY	1,160,568	0	1,160,568	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,512,714	352,146	1,160,568		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	106,583		1.00
2.00	50.00	OPERATING ROOM	0	0	0	245,563		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	352,146		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/13/2021 4:34 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		1	1.00
2.00	Line 1 multiplied by 15 hours per week		15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		1	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.75	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	6.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.29	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.15	41.15	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		494	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		494	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		494	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		82.33	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		1,235	22.00
23.00	Total salary equivalency (see instructions)		1,235	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		41	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		41	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		6	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		47	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		47	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/13/2021 4:34 pm

		Occupational Therapy				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.29	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	1,235	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	47	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	1,282	63.00
64.00	Total cost of outside supplier services (from your records)	399	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	41	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	6	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	47	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	6	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	6	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	34,912	34,912				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,790,307	0	2,790,307			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	518,521	0	0	518,521		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,870,154	0	0	0	1,870,154	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,024,022	3,210	114,182	88,447	133,220	5.00
7.00	00700	OPERATION OF PLANT	486,560	0	0	0	94,821	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,669,180	4,826	635,937	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	228,803	2,625	0	99,079	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	61,244	155	20,478	0	0	8.00
9.00	00900	HOUSEKEEPING	412,424	518	62,744	1,584	71,153	9.00
10.00	01000	DIETARY	435,286	1,279	0	48,268	79,680	10.00
11.00	01100	CAFETERIA	89,588	473	0	17,845	17,051	11.00
13.00	01300	NURSING ADMINISTRATION	1,054,776	502	33,532	9,353	178,344	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	456,198	1,374	181,003	0	0	14.00
15.00	01500	PHARMACY	1,026,300	587	77,302	0	82,555	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,886,955	3,792	499,675	0	319,378	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	832,450	2,484	327,407	0	95,964	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	406,920	941	123,985	0	63,813	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	129,647	193	25,476	0	14,346	55.00
56.00	05600	RADIOISOTOPE	141,359	133	17,566	0	27,831	56.00
57.00	05700	CT SCAN	432,134	182	23,972	0	84,263	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	154,422	257	33,823	0	29,834	58.00
60.00	06000	LABORATORY	1,447,376	854	112,532	0	0	60.00
66.00	06600	PHYSICAL THERAPY	452,885	827	109,038	0	88,967	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,420	66	8,686	0	34,550	67.00
68.00	06800	SPEECH PATHOLOGY	105,514	31	4,076	0	20,649	68.00
69.00	06900	ELECTROCARDIOLOGY	145,156	197	25,913	0	27,440	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,401	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,405	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	452,111	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,042,618	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	676,292	389	51,244	0	97,061	76.00
76.97	07697	CARDIAC REHABILITATION	69,476	471	0	17,789	13,559	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	162,788	450	59,299	0	30,310	90.00
91.00	09100	EMERGENCY	2,622,386	1,840	242,437	0	255,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,552,990	28,656	2,790,307	282,365	1,860,374	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,747	1,098	0	41,444	9,780	192.00
192.02	19202	MOB	0	4,074	0	153,782	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,084	0	40,930	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,612,737	34,912	2,790,307	518,521	1,870,154	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,363,081	8,363,081				5.00
7.00	00700	OPERATION OF PLANT	581,381	200,503	781,884			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,309,943	796,639	119,017	3,225,599		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	330,507	113,983	64,745	0	509,235	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	81,877	28,237	3,833	32,376	0	8.00
9.00	00900	HOUSEKEEPING	548,423	189,137	12,778	99,201	2,438	9.00
10.00	01000	DIETARY	564,513	194,686	31,541	0	74,260	10.00
11.00	01100	CAFETERIA	124,957	43,094	11,661	0	27,455	11.00
13.00	01300	NURSING ADMINISTRATION	1,276,507	440,234	12,388	53,015	14,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	638,575	220,228	33,875	286,171	0	14.00
15.00	01500	PHARMACY	1,186,744	409,277	14,467	122,217	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,709,800	934,540	93,516	790,001	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,258,305	433,957	61,275	517,639	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	595,659	205,427	23,204	196,023	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,662	58,512	4,768	40,279	0	55.00
56.00	05600	RADIOISOTOPE	186,889	64,453	3,288	27,773	0	56.00
57.00	05700	CT SCAN	540,551	186,422	4,486	37,900	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,336	75,298	6,330	53,475	0	58.00
60.00	06000	LABORATORY	1,560,762	538,266	21,061	177,917	0	60.00
66.00	06600	PHYSICAL THERAPY	651,717	224,760	20,407	172,393	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,722	75,776	1,626	13,733	0	67.00
68.00	06800	SPEECH PATHOLOGY	130,270	44,927	763	6,445	0	68.00
69.00	06900	ELECTROCARDIOLOGY	198,706	68,529	4,850	40,969	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,401	17,382	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,405	2,554	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	452,111	155,921	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,042,618	1,049,320	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	824,986	284,516	9,590	81,018	0	76.00
76.97	07697	CARDIAC REHABILITATION	101,295	34,934	11,625	0	27,369	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	252,847	87,200	11,098	93,754	0	90.00
91.00	09100	EMERGENCY	3,122,248	1,076,789	45,373	383,300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,300,798	8,255,501	627,565	3,225,599	145,912	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	112,069	38,650	27,082	0	63,761	192.00
192.02	19202	MOB	157,856	54,440	100,491	0	236,592	192.02
192.03	19203	ARNETT SURGERY OFFICE	42,014	14,490	26,746	0	62,970	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,612,737	8,363,081	781,884	3,225,599	509,235	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	146,323					8.00
9.00	00900	HOUSEKEEPING	0	851,977				9.00
10.00	01000	DIETARY	0	29,087	894,087			10.00
11.00	01100	CAFETERIA	0	10,677	0	217,844		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,418	0	19,318	1,820,270	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,418	0	0	0	14.00
15.00	01500	PHARMACY	0	23,564	0	8,276	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	146,323	192,561	894,087	47,693	988,676	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	104,932	0	12,825	168,515	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,609	0	9,699	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,995	0	1,583	0	55.00
56.00	05600	RADIOISOTOPE	0	4,786	0	3,166	0	56.00
57.00	05700	CT SCAN	0	6,627	0	11,262	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,573	0	4,028	0	58.00
60.00	06000	LABORATORY	0	32,400	0	20,219	0	60.00
66.00	06600	PHYSICAL THERAPY	0	26,877	0	10,040	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,209	0	3,827	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,105	0	2,064	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,847	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	32,032	0	14,308	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	11,414	0	2,124	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24,300	0	5,090	63,889	90.00
91.00	09100	EMERGENCY	0	111,928	0	35,589	599,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	146,323	674,512	894,087	214,958	1,820,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,137	0	2,886	0	192.00
192.02	19202	MOB	0	144,328	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	146,323	851,977	894,087	217,844	1,820,270	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	1,183,267					14.00
15.00	01500	PHARMACY	52,913	1,817,458				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	279,242	7,355	0	7,083,794	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,825	1,456	0	2,595,729	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,478	1,023	0	1,074,122	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,656	21	0	283,476	0	55.00
56.00	05600	RADIOISOTOPE	14,010	334	0	304,699	0	56.00
57.00	05700	CT SCAN	116,738	21	0	904,007	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	32,209	3	0	399,252	0	58.00
60.00	06000	LABORATORY	0	0	0	2,350,625	0	60.00
66.00	06600	PHYSICAL THERAPY	18,179	0	0	1,124,373	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	970	0	0	317,863	0	67.00
68.00	06800	SPEECH PATHOLOGY	5	0	0	185,579	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,546	45	0	328,492	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,046	0	0	193,829	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,519	0	0	28,478	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	231,801	0	839,833	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	1,559,972	0	5,651,910	0	73.01
76.00	03160	CARDIOPULMONARY	84,712	113	0	1,331,275	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,768	0	0	191,529	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,867	5,426	0	570,471	0	90.00
91.00	09100	EMERGENCY	347,930	9,888	0	5,732,235	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,179,613	1,817,458	0	31,491,571	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,654	0	0	281,239	0	192.00
192.02	19202	MOB	0	0	0	693,707	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	146,220	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,183,267	1,817,458	0	32,612,737	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,083,794		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,595,729		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,074,122		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	283,476		55.00
56.00	05600	RADIOISOTOPE	304,699		56.00
57.00	05700	CT SCAN	904,007		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	399,252		58.00
60.00	06000	LABORATORY	2,350,625		60.00
66.00	06600	PHYSICAL THERAPY	1,124,373		66.00
67.00	06700	OCCUPATIONAL THERAPY	317,863		67.00
68.00	06800	SPEECH PATHOLOGY	185,579		68.00
69.00	06900	ELECTROCARDIOLOGY	328,492		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,829		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,478		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	839,833		73.00
73.01	07301	ONCOLOGY DRUGS	5,651,910		73.01
76.00	03160	CARDIOPULMONARY	1,331,275		76.00
76.97	07697	CARDIAC REHABILITATION	191,529		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	570,471		90.00
91.00	09100	EMERGENCY	5,732,235		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,491,571		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	281,239		192.00
192.02	19202	MOB	693,707		192.02
192.03	19203	ARNETT SURGERY OFFICE	146,220		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	32,612,737		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	247,441	3,210	114,182	88,447	453,280	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	4,826	635,937	0	640,763	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	2,625	0	99,079	101,704	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	155	20,478	0	20,633	8.00
9.00	00900	HOUSEKEEPING	0	518	62,744	1,584	64,846	9.00
10.00	01000	DIETARY	0	1,279	0	48,268	49,547	10.00
11.00	01100	CAFETERIA	0	473	0	17,845	18,318	11.00
13.00	01300	NURSING ADMINISTRATION	0	502	33,532	9,353	43,387	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,374	181,003	0	182,377	14.00
15.00	01500	PHARMACY	0	587	77,302	0	77,889	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,792	499,675	0	503,467	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,484	327,407	0	329,891	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	941	123,985	0	124,926	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	193	25,476	0	25,669	55.00
56.00	05600	RADIOISOTOPE	0	133	17,566	0	17,699	56.00
57.00	05700	CT SCAN	0	182	23,972	0	24,154	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	257	33,823	0	34,080	58.00
60.00	06000	LABORATORY	0	854	112,532	0	113,386	60.00
66.00	06600	PHYSICAL THERAPY	0	827	109,038	0	109,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66	8,686	0	8,752	67.00
68.00	06800	SPEECH PATHOLOGY	0	31	4,076	0	4,107	68.00
69.00	06900	ELECTROCARDIOLOGY	0	197	25,913	0	26,110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	389	51,244	0	51,633	76.00
76.97	07697	CARDIAC REHABILITATION	0	471	0	17,789	18,260	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	450	59,299	0	59,749	90.00
91.00	09100	EMERGENCY	0	1,840	242,437	0	244,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	247,441	28,656	2,790,307	282,365	3,348,769	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,098	0	41,444	42,542	192.00
192.02	19202	MOB	0	4,074	0	153,782	157,856	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,084	0	40,930	42,014	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	247,441	34,912	2,790,307	518,521	3,591,181	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	453,280				5.00
7.00	00700	OPERATION OF PLANT	0	10,867	10,867			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	43,177	1,652	685,592		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	6,178	900	0	108,782	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,530	53	6,882	0	8.00
9.00	00900	HOUSEKEEPING	0	10,251	178	21,085	521	9.00
10.00	01000	DIETARY	0	10,552	438	0	15,863	10.00
11.00	01100	CAFETERIA	0	2,336	162	0	5,865	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,860	172	11,268	3,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,936	471	60,825	0	14.00
15.00	01500	PHARMACY	0	22,183	201	25,977	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,652	1,300	167,911	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,520	852	110,023	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,134	323	41,664	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,171	66	8,561	0	55.00
56.00	05600	RADIOISOTOPE	0	3,493	46	5,903	0	56.00
57.00	05700	CT SCAN	0	10,104	62	8,056	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,081	88	11,366	0	58.00
60.00	06000	LABORATORY	0	29,174	293	37,816	0	60.00
66.00	06600	PHYSICAL THERAPY	0	12,182	284	36,642	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,107	23	2,919	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,435	11	1,370	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,714	67	8,708	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	942	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,451	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	56,873	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	15,421	133	17,220	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,893	162	0	5,847	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,726	154	19,927	0	90.00
91.00	09100	EMERGENCY	0	58,368	631	81,469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	447,449	8,722	685,592	31,170	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,095	376	0	13,621	192.00
192.02	19202	MOB	0	2,951	1,397	0	50,539	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	785	372	0	13,452	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	453,280	10,867	685,592	108,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,098					8.00
9.00	00900	HOUSEKEEPING	0	96,881				9.00
10.00	01000	DIETARY	0	3,308	79,708			10.00
11.00	01100	CAFETERIA	0	1,214	0	27,895		11.00
13.00	01300	NURSING ADMINISTRATION	0	502	0	2,474	84,737	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	502	0	0	0	14.00
15.00	01500	PHARMACY	0	2,680	0	1,060	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,098	21,897	79,708	6,106	46,025	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,932	0	1,642	7,845	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,936	0	1,242	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	795	0	203	0	55.00
56.00	05600	RADIOISOTOPE	0	544	0	405	0	56.00
57.00	05700	CT SCAN	0	754	0	1,442	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,089	0	516	0	58.00
60.00	06000	LABORATORY	0	3,684	0	2,589	0	60.00
66.00	06600	PHYSICAL THERAPY	0	3,056	0	1,286	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251	0	490	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	126	0	264	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	493	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	3,642	0	1,832	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,298	0	272	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,763	0	652	2,974	90.00
91.00	09100	EMERGENCY	0	12,728	0	4,557	27,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,098	76,701	79,708	27,525	84,737	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,768	0	370	0	192.00
192.02	19202	MOB	0	16,412	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	29,098	96,881	79,708	27,895	84,737	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	256,111					14.00
15.00	01500	PHARMACY	11,453	141,443				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,440	572	0	967,176	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,971	113	0	493,789	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,835	80	0	185,140	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	358	2	0	38,825	0	55.00
56.00	05600	RADIOISOTOPE	3,032	26	0	31,148	0	56.00
57.00	05700	CT SCAN	25,267	2	0	69,841	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,971	0	0	58,191	0	58.00
60.00	06000	LABORATORY	0	0	0	186,942	0	60.00
66.00	06600	PHYSICAL THERAPY	3,935	0	0	167,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	210	0	0	16,752	0	67.00
68.00	06800	SPEECH PATHOLOGY	1	0	0	8,314	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,499	3	0	41,594	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,282	0	0	28,224	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,008	0	0	4,146	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,040	0	26,491	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	121,405	0	178,278	0	73.01
76.00	03160	CARDIOPULMONARY	18,335	9	0	108,225	0	76.00
76.97	07697	CARDIAC REHABILITATION	599	0	0	28,331	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,815	422	0	97,182	0	90.00
91.00	09100	EMERGENCY	75,309	769	0	506,001	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	255,320	141,443	0	3,241,840	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	791	0	0	63,563	0	192.00
192.02	19202	MOB	0	0	0	229,155	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	56,623	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	256,111	141,443	0	3,591,181	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	967,176		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	493,789		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,140		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	38,825		55.00
56.00	05600	RADIOISOTOPE	31,148		56.00
57.00	05700	CT SCAN	69,841		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58,191		58.00
60.00	06000	LABORATORY	186,942		60.00
66.00	06600	PHYSICAL THERAPY	167,250		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,752		67.00
68.00	06800	SPEECH PATHOLOGY	8,314		68.00
69.00	06900	ELECTROCARDIOLOGY	41,594		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,224		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,146		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,491		73.00
73.01	07301	ONCOLOGY DRUGS	178,278		73.01
76.00	03160	CARDIOPULMONARY	108,225		76.00
76.97	07697	CARDIAC REHABILITATION	28,331		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	97,182		90.00
91.00	09100	EMERGENCY	506,001		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,241,840		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	63,563		192.00
192.02	19202	MOB	229,155		192.02
192.03	19203	ARNETT SURGERY OFFICE	56,623		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,591,181		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	94,810					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	57,501				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	37,309			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	8,884,521		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,717	2,353	6,364	632,888	-8,363,081	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	450,465	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	13,105	13,105	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	7,129	0	7,129	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	422	422	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,407	1,293	114	338,027	0	9.00
10.00	01000	DIETARY	3,473	0	3,473	378,535	0	10.00
11.00	01100	CAFETERIA	1,284	0	1,284	81,006	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,364	691	673	847,258	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	0	0	14.00
15.00	01500	PHARMACY	1,593	1,593	0	392,195	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,297	10,297	0	1,517,264	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,747	6,747	0	455,897	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555	2,555	0	303,157	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	525	525	0	68,154	0	55.00
56.00	05600	RADIOISOTOPE	362	362	0	132,218	0	56.00
57.00	05700	CT SCAN	494	494	0	400,309	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	697	697	0	141,730	0	58.00
60.00	06000	LABORATORY	2,319	2,319	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,247	2,247	0	422,654	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	179	0	164,136	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	98,095	0	68.00
69.00	06900	ELECTROCARDIOLOGY	534	534	0	130,357	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,056	1,056	0	461,104	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,280	0	1,280	64,415	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,222	1,222	0	143,992	0	90.00
91.00	09100	EMERGENCY	4,996	4,996	0	1,214,204	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,818	57,501	20,317	8,838,060	-8,363,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,982	0	2,982	46,461	0	192.00
192.02	19202	MOB	11,065	0	11,065	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	2,945	0	2,945	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	34,912	2,790,307	518,521	1,870,154		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.368231	48.526234	13.898014	0.210496		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,249,656					5.00
7.00	00700	OPERATION OF PLANT	581,381	86,093				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,309,943	13,105	42,043			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	330,507	7,129	0	23,816		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	81,877	422	422	0	2,998	8.00
9.00	00900	HOUSEKEEPING	548,423	1,407	1,293	114	0	9.00
10.00	01000	DIETARY	564,513	3,473	0	3,473	0	10.00
11.00	01100	CAFETERIA	124,957	1,284	0	1,284	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,276,507	1,364	691	673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	638,575	3,730	3,730	0	0	14.00
15.00	01500	PHARMACY	1,186,744	1,593	1,593	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,709,800	10,297	10,297	0	2,998	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,258,305	6,747	6,747	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	595,659	2,555	2,555	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,662	525	525	0	0	55.00
56.00	05600	RADIOISOTOPE	186,889	362	362	0	0	56.00
57.00	05700	CT SCAN	540,551	494	494	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,336	697	697	0	0	58.00
60.00	06000	LABORATORY	1,560,762	2,319	2,319	0	0	60.00
66.00	06600	PHYSICAL THERAPY	651,717	2,247	2,247	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,722	179	179	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	130,270	84	84	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	198,706	534	534	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,401	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,405	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	452,111	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,042,618	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	824,986	1,056	1,056	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	101,295	1,280	0	1,280	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	252,847	1,222	1,222	0	0	90.00
91.00	09100	EMERGENCY	3,122,248	4,996	4,996	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,937,717	69,101	42,043	6,824	2,998	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	112,069	2,982	0	2,982	0	192.00
192.02	19202	MOB	157,856	11,065	0	11,065	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	42,014	2,945	0	2,945	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	8,363,081	781,884	3,225,599	509,235	146,323	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.344874	9.081853	76.721428	21.382054	48.806871	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	453,280	10,867	685,592	108,782	29,098	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.018692	0.126224	16.306924	4.567602	9.705804	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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,314					9.00
10.00	01000	DIETARY	79	2,998				10.00
11.00	01100	CAFETERIA	29	0	10,871			11.00
13.00	01300	NURSING ADMINISTRATION	12	0	964	76,898		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	0	0	0	473,143	14.00
15.00	01500	PHARMACY	64	0	413	0	21,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	523	2,998	2,380	41,767	111,658	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	285	0	640	7,119	14,725	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94	0	484	0	3,390	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19	0	79	0	662	55.00
56.00	05600	RADIOISOTOPE	13	0	158	0	5,602	56.00
57.00	05700	CT SCAN	18	0	562	0	46,679	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26	0	201	0	12,879	58.00
60.00	06000	LABORATORY	88	0	1,009	0	0	60.00
66.00	06600	PHYSICAL THERAPY	73	0	501	0	7,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	6	0	191	0	388	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	103	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	192	0	4,617	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	50,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	87	0	714	0	33,873	76.00
76.97	07697	CARDIAC REHABILITATION	31	0	106	0	1,107	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	66	0	254	2,699	10,743	90.00
91.00	09100	EMERGENCY	304	0	1,776	25,313	139,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,832	2,998	10,727	76,898	471,682	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	90	0	144	0	1,461	192.00
192.02	19202	MOB	392	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	851,977	894,087	217,844	1,820,270	1,183,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	368.183665	298.227819	20.039003	23.671227	2.500865	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	96,881	79,708	27,895	84,737	256,111	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	41.867329	26.587058	2.566001	1.101940	0.541297	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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/13/2021 4:34 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
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	3,544,824			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	14,346	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,839	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,996	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	40	0		55.00
56.00	05600	RADIOISOTOPE	652	0		56.00
57.00	05700	CT SCAN	41	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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	87	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	452,111	0		73.00
73.01	07301	ONCOLOGY DRUGS	3,042,618	0		73.01
76.00	03160	CARDIOPULMONARY	220	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	10,583	0		90.00
91.00	09100	EMERGENCY	19,285	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,544,824	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,817,458	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.512708	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	141,443	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.039901	0.000000		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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/13/2021 4:34 pm

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	7,083,794		7,083,794	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,595,729		2,595,729	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,074,122		1,074,122	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	283,476		283,476	0	0	55.00
56.00	05600	RADIOISOTOPE	304,699		304,699	0	0	56.00
57.00	05700	CT SCAN	904,007		904,007	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	399,252		399,252	0	0	58.00
60.00	06000	LABORATORY	2,350,625		2,350,625	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,124,373	0	1,124,373	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,863	0	317,863	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	185,579	0	185,579	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	328,492		328,492	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,829		193,829	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,478		28,478	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	839,833		839,833	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	5,651,910		5,651,910	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,331,275		1,331,275	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	191,529		191,529	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	570,471		570,471	0	0	90.00
91.00	09100	EMERGENCY	5,732,235		5,732,235	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,308,509		1,308,509		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	32,800,080	0	32,800,080	0	0	200.00
201.00		Less Observation Beds	1,308,509		1,308,509		0	201.00
202.00		Total (see instructions)	31,491,571	0	31,491,571	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/13/2021 4:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,168,687		5,168,687			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,453,502	5,453,502	0.475975	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,000	4,874,245	4,961,245	0.216503	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,780	852,520	862,300	0.328744	0.000000	55.00
56.00	05600	RADIOISOTOPE	134,789	1,969,678	2,104,467	0.144787	0.000000	56.00
57.00	05700	CT SCAN	354,633	5,144,803	5,499,436	0.164382	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	105,648	1,215,908	1,321,556	0.302108	0.000000	58.00
60.00	06000	LABORATORY	1,018,183	5,679,425	6,697,608	0.350965	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	758,508	1,305,739	2,064,247	0.544689	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	465,172	186,719	651,891	0.487601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,570	162,848	235,418	0.788296	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,149	1,334,936	1,336,085	0.245862	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,213	336,611	346,824	0.558868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,331	41,331	0.689023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,472,471	3,459,764	5,932,235	0.141571	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	15,158,525	15,158,525	0.372854	0.000000	73.01
76.00	03160	CARDIOPULMONARY	1,103,687	2,895,360	3,999,047	0.332898	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	608,626	608,626	0.314691	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,960,246	3,960,246	0.144049	0.000000	90.00
91.00	09100	EMERGENCY	706,412	24,544,908	25,251,320	0.227007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,150	3,367,692	3,370,842	0.388185	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	12,472,052	82,553,386	95,025,438			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,472,052	82,553,386	95,025,438			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/13/2021 4:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/13/2021 4:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,083,794		7,083,794	0	7,083,794	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,595,729		2,595,729	0	2,595,729	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,074,122		1,074,122	0	1,074,122	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	283,476		283,476	0	283,476	55.00
56.00	05600	RADIOISOTOPE	304,699		304,699	0	304,699	56.00
57.00	05700	CT SCAN	904,007		904,007	0	904,007	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	399,252		399,252	0	399,252	58.00
60.00	06000	LABORATORY	2,350,625		2,350,625	0	2,350,625	60.00
66.00	06600	PHYSICAL THERAPY	1,124,373	0	1,124,373	0	1,124,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,863	0	317,863	0	317,863	67.00
68.00	06800	SPEECH PATHOLOGY	185,579	0	185,579	0	185,579	68.00
69.00	06900	ELECTROCARDIOLOGY	328,492		328,492	0	328,492	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,829		193,829	0	193,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,478		28,478	0	28,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	839,833		839,833	0	839,833	73.00
73.01	07301	ONCOLOGY DRUGS	5,651,910		5,651,910	0	5,651,910	73.01
76.00	03160	CARDIOPULMONARY	1,331,275		1,331,275	0	1,331,275	76.00
76.97	07697	CARDIAC REHABILITATION	191,529		191,529	0	191,529	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	570,471		570,471	0	570,471	90.00
91.00	09100	EMERGENCY	5,732,235		5,732,235	0	5,732,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,308,509		1,308,509		1,308,509	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	32,800,080	0	32,800,080	0	32,800,080	200.00
201.00		Less Observation Beds	1,308,509		1,308,509		1,308,509	201.00
202.00		Total (see instructions)	31,491,571	0	31,491,571	0	31,491,571	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/13/2021 4:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,168,687		5,168,687			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,453,502	5,453,502	0.475975	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,000	4,874,245	4,961,245	0.216503	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,780	852,520	862,300	0.328744	0.000000	55.00
56.00	05600	RADIOISOTOPE	134,789	1,969,678	2,104,467	0.144787	0.000000	56.00
57.00	05700	CT SCAN	354,633	5,144,803	5,499,436	0.164382	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	105,648	1,215,908	1,321,556	0.302108	0.000000	58.00
60.00	06000	LABORATORY	1,018,183	5,679,425	6,697,608	0.350965	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	758,508	1,305,739	2,064,247	0.544689	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	465,172	186,719	651,891	0.487601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,570	162,848	235,418	0.788296	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,149	1,334,936	1,336,085	0.245862	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,213	336,611	346,824	0.558868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,331	41,331	0.689023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,472,471	3,459,764	5,932,235	0.141571	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	15,158,525	15,158,525	0.372854	0.000000	73.01
76.00	03160	CARDIOPULMONARY	1,103,687	2,895,360	3,999,047	0.332898	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	608,626	608,626	0.314691	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,960,246	3,960,246	0.144049	0.000000	90.00
91.00	09100	EMERGENCY	706,412	24,544,908	25,251,320	0.227007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,150	3,367,692	3,370,842	0.388185	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	12,472,052	82,553,386	95,025,438			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,472,052	82,553,386	95,025,438			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/13/2021 4:34 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/13/2021 4:34 pm

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	493,789	5,453,502	0.090545	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,140	4,961,245	0.037317	31,543	1,177	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	38,825	862,300	0.045025	2,388	108	55.00
56.00	05600	RADIOISOTOPE	31,148	2,104,467	0.014801	64,379	953	56.00
57.00	05700	CT SCAN	69,841	5,499,436	0.012700	96,029	1,220	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58,191	1,321,556	0.044032	59,817	2,634	58.00
60.00	06000	LABORATORY	186,942	6,697,608	0.027912	410,131	11,448	60.00
66.00	06600	PHYSICAL THERAPY	167,250	2,064,247	0.081022	168,432	13,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,752	651,891	0.025698	78,043	2,006	67.00
68.00	06800	SPEECH PATHOLOGY	8,314	235,418	0.035316	28,622	1,011	68.00
69.00	06900	ELECTROCARDIOLOGY	41,594	1,336,085	0.031131	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,224	346,824	0.081378	4,384	357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,146	41,331	0.100312	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,491	5,932,235	0.004466	820,011	3,662	73.00
73.01	07301	ONCOLOGY DRUGS	178,278	15,158,525	0.011761	0	0	73.01
76.00	03160	CARDIOPULMONARY	108,225	3,999,047	0.027063	540,859	14,637	76.00
76.97	07697	CARDIAC REHABILITATION	28,331	608,626	0.046549	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	97,182	3,960,246	0.024539	0	0	90.00
91.00	09100	EMERGENCY	506,001	25,251,320	0.020039	27,048	542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	178,656	3,370,842	0.053000	356	19	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	2,453,320	89,856,751		2,332,042	53,421	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/13/2021 4:34 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/13/2021 4:34 pm

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	5,453,502	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,961,245	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	862,300	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,104,467	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	5,499,436	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,321,556	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	6,697,608	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,064,247	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	651,891	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	235,418	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,336,085	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	346,824	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41,331	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,932,235	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	15,158,525	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	3,999,047	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	608,626	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	3,960,246	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,251,320	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,370,842	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	89,856,751		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/13/2021 4:34 pm

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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	31,543	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	2,388	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	64,379	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	96,029	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	59,817	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	410,131	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	168,432	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	78,043	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	28,622	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,384	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	820,011	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	540,859	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	27,048	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	356	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		2,332,042	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/13/2021 4:34 pm

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	0.475975	0	1,716,624	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216503	0	1,142,924	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.328744	0	374,456	0	0	55.00
56.00	05600	RADIOISOTOPE	0.144787	0	679,424	0	0	56.00
57.00	05700	CT SCAN	0.164382	0	1,736,240	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.302108	0	431,495	0	0	58.00
60.00	06000	LABORATORY	0.350965	0	1,885,881	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.544689	0	480,465	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.487601	0	52,592	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.788296	0	35,568	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.245862	0	360,885	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558868	0	127,252	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.689023	0	8,860	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141571	0	771,654	1,100	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.372854	0	7,830,053	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.332898	0	1,072,824	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.314691	0	270,103	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.144049	0	2,014,113	0	0	90.00
91.00	09100	EMERGENCY	0.227007	0	5,960,308	623	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388185	0	1,342,496	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	28,294,217	1,723	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	28,294,217	1,723	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/13/2021 4:34 pm

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	817,070	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,446	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	123,100	0		55.00
56.00	05600	RADIOISOTOPE	98,372	0		56.00
57.00	05700	CT SCAN	285,407	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	130,358	0		58.00
60.00	06000	LABORATORY	661,878	0		60.00
66.00	06600	PHYSICAL THERAPY	261,704	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	25,644	0		67.00
68.00	06800	SPEECH PATHOLOGY	28,038	0		68.00
69.00	06900	ELECTROCARDIOLOGY	88,728	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,117	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,105	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,244	156		73.00
73.01	07301	ONCOLOGY DRUGS	2,919,467	0		73.01
76.00	03160	CARDIOPULMONARY	357,141	0		76.00
76.97	07697	CARDIAC REHABILITATION	84,999	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	290,131	0		90.00
91.00	09100	EMERGENCY	1,353,032	141		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	521,137	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	8,480,118	297		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,480,118	297		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/13/2021 4:34 pm

Title XVIII | Hospital

	Cost Center Description	Cost 1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,549	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,465	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,914	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	461	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	623	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)	1,026	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)	461	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)	7,083,794	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)	135,160	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)	1,229,938	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,853,856	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,853,856	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)	2,374.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,436,535	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)	2,436,535	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/13/2021 4:34 pm

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						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)	651,962	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,088,497	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)	1,094,778	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)	1,094,778	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)	551	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,374.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,308,509	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/13/2021 4:34 pm

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	967,176	7,083,794	0.136534	1,308,509	178,656	90.00
91.00	Nursing School cost	0	7,083,794	0.000000	1,308,509	0	91.00
92.00	Allied health cost	0	7,083,794	0.000000	1,308,509	0	92.00
93.00	All other Medical Education	0	7,083,794	0.000000	1,308,509	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/13/2021 4:34 pm

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)	3,549	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,465	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,914	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	461	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	623	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)	17	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)	7,083,794	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)	135,160	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)	1,229,938	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,853,856	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,853,856	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)	2,374.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	40,371	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)	40,371	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/13/2021 4:34 pm

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						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)	22,890	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	63,261	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)	551	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,374.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,308,509	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/13/2021 4:34 pm

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	967,176	7,083,794	0.136534	1,308,509	178,656	90.00
91.00	Nursing School cost	0	7,083,794	0.000000	1,308,509	0	91.00
92.00	Allied health cost	0	7,083,794	0.000000	1,308,509	0	92.00
93.00	All other Medical Education	0	7,083,794	0.000000	1,308,509	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/13/2021 4:34 pm

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		2,181,778		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475975	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216503	31,543	6,829	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.328744	2,388	785	55.00
56.00	05600	RADIOISOTOPE	0.144787	64,379	9,321	56.00
57.00	05700	CT SCAN	0.164382	96,029	15,785	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.302108	59,817	18,071	58.00
60.00	06000	LABORATORY	0.350965	410,131	143,942	60.00
66.00	06600	PHYSICAL THERAPY	0.544689	168,432	91,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.487601	78,043	38,054	67.00
68.00	06800	SPEECH PATHOLOGY	0.788296	28,622	22,563	68.00
69.00	06900	ELECTROCARDIOLOGY	0.245862	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558868	4,384	2,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.689023	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141571	820,011	116,090	73.00
73.01	07301	ONCOLOGY DRUGS	0.372854	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.332898	540,859	180,051	76.00
76.97	07697	CARDIAC REHABILITATION	0.314691	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.144049	0	0	90.00
91.00	09100	EMERGENCY	0.227007	27,048	6,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388185	356	138	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,332,042	651,962	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)		2,332,042		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3

Component CCN:15-Z312 | Date/Time Prepared: 7/13/2021 4:34 pm

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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475975	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216503	7,244	1,568	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.328744	0	0	55.00
56.00	05600	RADIOISOTOPE	0.144787	12,160	1,761	56.00
57.00	05700	CT SCAN	0.164382	8,254	1,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.302108	0	0	58.00
60.00	06000	LABORATORY	0.350965	65,941	23,143	60.00
66.00	06600	PHYSICAL THERAPY	0.544689	193,229	105,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.487601	145,547	70,969	67.00
68.00	06800	SPEECH PATHOLOGY	0.788296	10,042	7,916	68.00
69.00	06900	ELECTROCARDIOLOGY	0.245862	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558868	486	272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.689023	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141571	152,790	21,631	73.00
73.01	07301	ONCOLOGY DRUGS	0.372854	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.332898	54,164	18,031	76.00
76.97	07697	CARDIAC REHABILITATION	0.314691	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.144049	0	0	90.00
91.00	09100	EMERGENCY	0.227007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388185	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		649,857	251,898	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)		649,857		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/13/2021 4:34 pm

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		32,828		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.475975	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216503	1,112	241	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.328744	0	0	55.00
56.00	05600	RADIOISOTOPE	0.144787	3,022	438	56.00
57.00	05700	CT SCAN	0.164382	5,816	956	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.302108	1,523	460	58.00
60.00	06000	LABORATORY	0.350965	9,372	3,289	60.00
66.00	06600	PHYSICAL THERAPY	0.544689	2,561	1,395	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.487601	793	387	67.00
68.00	06800	SPEECH PATHOLOGY	0.788296	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.245862	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558868	137	77	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.689023	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141571	68,835	9,745	73.00
73.01	07301	ONCOLOGY DRUGS	0.372854	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.332898	5,955	1,982	76.00
76.97	07697	CARDIAC REHABILITATION	0.314691	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.144049	0	0	90.00
91.00	09100	EMERGENCY	0.227007	17,268	3,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388185	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		116,394	22,890	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)		116,394		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/13/2021 4:34 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,480,415	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)	8,480,415	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)	8,565,219	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)	72,574	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,131,770	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)	3,360,875	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)	3,360,875	30.00
31.00	Primary payer payments	475	31.00
32.00	Subtotal (line 30 minus line 31)	3,360,400	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)	366,518	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	238,237	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	152,183	36.00
37.00	Subtotal (see instructions)	3,598,637	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)	3,598,637	40.00
40.01	Sequestration adjustment (see instructions)	23,751	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	3,640,157	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)	-65,271	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	378,138	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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

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		2,777,827		3,640,157	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	08/18/2020	187,000		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)		187,000		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)		2,964,827		3,640,157	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		123,083		65,271	6.02
7.00	Total Medicare program liability (see instructions)		2,841,744		3,574,886	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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/13/2021 4:34 pm

Component CCN:15-Z312 | 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		1,367,774		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	08/18/2020	30,300		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)		30,300		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)		1,398,074		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		56,174		0	6.02
7.00	Total Medicare program liability (see instructions)		1,341,900		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:15-1312	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/13/2021 4:34 pm
	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:15-1312 | Component CCN:15-Z312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/13/2021 4:34 pm

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)	1,105,726	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)	254,417	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	461	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)	1,360,143	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,360,143	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)	1,360,143	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,328	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,350,815	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)	1,350,815	0	19.00
19.01	Sequestration adjustment (see instructions)	8,915	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	1,398,074	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)	-56,174	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	61,231	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:15-1312	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/13/2021 4:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,088,497	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)	3,088,497	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,119,382	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)	3,119,382	19.00
20.00	Deductibles (exclude professional component)	275,704	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,843,678	22.00
23.00	Coinsurance	3,872	23.00
24.00	Subtotal (line 22 minus line 23)	2,839,806	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	32,028	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,818	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,436	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,860,624	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)	2,860,624	30.00
30.01	Sequestration adjustment (see instructions)	18,880	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,964,827	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)	-123,083	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	140,060	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/13/2021 4:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	36,659,776	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	1,924,608	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	359,191	0	0	0	7.00
8.00	Prepaid expenses	169,819	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	39,113,394	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	122,178	0	0	0	13.00
14.00	Accumulated depreciation	-108,161	0	0	0	14.00
15.00	Buildings	30,277,094	0	0	0	15.00
16.00	Accumulated depreciation	-7,509,647	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	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,924,909	0	0	0	23.00
24.00	Accumulated depreciation	-7,191,964	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,487,188	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	151,650	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,317	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	158,967	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	66,759,549	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	798,860	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,088,573	0	0	0	38.00
39.00	Payroll taxes payable	53,598	0	0	0	39.00
40.00	Notes and loans payable (short term)	650,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	7,368,735				42.00
43.00	Due to other funds	3,561,085	0	0	0	43.00
44.00	Other current liabilities	7,317	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,528,168	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	19,015,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	31,084	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,046,084	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,574,252	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,185,297				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)	34,185,297	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	66,759,549	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/13/2021 4:34 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		29,260,730		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,944,677				2.00
3.00	Total (sum of line 1 and line 2)		34,205,407		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET INTERCOMPANY TRANSACTIONS	-20,111		0		0	5.00
6.00		0		0		0	6.00
7.00	ROUNDING	1		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)		-20,110		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,185,297		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)		34,185,297		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	NET INTERCOMPANY TRANSACTIONS		0			5.00
6.00			0			6.00
7.00	ROUNDING		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:15-1312 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/13/2021 4:34 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,245,741		4,245,741	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	922,946		922,946	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)	5,168,687		5,168,687	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,168,687		5,168,687	17.00
18.00	Ancillary services	6,593,803	50,680,540	57,274,343	18.00
19.00	Outpatient services	709,562	31,872,846	32,582,408	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,472,052	82,553,386	95,025,438	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,428,597		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)		31,428,597		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN:15-1312	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 7/13/2021 4:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	95,025,438	1.00
2.00	Less contractual allowances and discounts on patients' accounts	59,960,287	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,065,151	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,428,597	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,636,554	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	1,073,126	24.00
24.50	COVID-19 PHE Funding	234,997	24.50
25.00	Total other income (sum of lines 6-24)	1,308,123	25.00
26.00	Total (line 5 plus line 25)	4,944,677	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,944,677	29.00