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: 15-1304

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

Worksheet S
Parts I-III
Date/Time Prepared:
7/27/2021 7:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/27/2021 Time: 7:43 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) 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) ASHLEY KINDER
Officer or Administrator of Provider(s)

VP OF FINANCE AND CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	220,374	-849,897	0	71,599	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	13,227	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		341,054		0	10.00
200.00	Total	0	233,601	-508,843	0	71,599	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 7:43 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	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	RUSH SWING BEDS	15Z304	99915		08/01/2000	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RMH HEALTHCARE ASSOC	158539	99915		06/12/2019	N	O	O	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			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 7:43 am

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 7:43 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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

		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

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	135,109	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 7:43 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 7:43 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/27/2021 7:43 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/25/2021	Y	02/25/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/27/2021 7:43 am

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON	HACKETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929	LHACKETT@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/27/2021 7:43 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/27/2021 7:43 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	26,496.00	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	26,496.00	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	26,496.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2021 7:43 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	693	33	1,104			1.00
2.00	HMO and other (see instructions)	20	34				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	87	0	87			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	13			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	780	33	1,204			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)	780	33	1,204	0.00	243.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,937	1,079	10,305	0.00	25.44	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	268.59	27.00
28.00	Observation Bed Days		13	661			28.00
29.00	Ambulance Trips	159					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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2021 7:43 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	215	10	337	1.00
2.00	HMO and other (see instructions)			7	12		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	215	10	337	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/27/2021 7:43 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	201 CONRAD HARCOURT WAY	1.00

		City	State	ZIP Code	County	
		1.00	2.00	3.00	4.00	
2.00	City, State, ZIP Code, County	RUSHVILLE	IN	46173	RUSH	2.00

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

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

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

		Sunday from	Sunday to	Monday from	Monday to	Tuesday from	Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)											
11.00	CLINIC			08:00	05:00	08:00	05:00	08:00	05:00	08:00	05:00	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2020 To 12/31/2020	Worksheet S-8 Date/Time Prepared: 7/27/2021 7:43 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/27/2021 7:43 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.345031	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	952,504	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	12,166,163	6.00
7.00	Medicaid cost (line 1 times line 6)	4,197,703	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)	3,245,199	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,245,199	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)	35,786	73,133	108,919	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	12,347	73,133	85,480	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)	12,347	73,133	85,480	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,094,601	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	731,344	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,125,144	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,969,457	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,763,386	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,848,866	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,094,065	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,278,225	2,278,225	0	2,278,225	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	385,111	4,229,053	4,614,164	14,743	4,628,907	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,078,248	8,367,223	11,445,471	-118,019	11,327,452	5.00
7.00	00700	OPERATION OF PLANT	321,918	757,945	1,079,863	36,857	1,116,720	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,803	97,803	0	97,803	8.00
9.00	00900	HOUSEKEEPING	534,519	168,047	702,566	36,838	739,404	9.00
10.00	01000	DIETARY	330,039	109,034	439,073	-298,844	140,229	10.00
11.00	01100	CAFETERIA	0	0	0	328,334	328,334	11.00
13.00	01300	NURSING ADMINISTRATION	173,611	14,227	187,838	0	187,838	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,550	65,453	135,003	-482	134,521	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	317,195	69,337	386,532	0	386,532	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,795,505	141,043	1,936,548	-714,197	1,222,351	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,193,932	573,197	1,767,129	-420,858	1,346,271	50.00
51.00	05100	RECOVERY ROOM	0	11,951	11,951	45,135	57,086	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,087,681	601,779	1,689,460	-64,921	1,624,539	54.00
54.01	05401	ONCOLOGY	311,102	300,943	612,045	0	612,045	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	737,101	1,102,435	1,839,536	0	1,839,536	60.00
65.00	06500	RESPIRATORY THERAPY	132,393	31,437	163,830	-11,524	152,306	65.00
66.00	06600	PHYSICAL THERAPY	268,622	5,291	273,913	34,583	308,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,558	2,606	170,164	34,516	204,680	67.00
68.00	06800	SPEECH PATHOLOGY	162,067	949	163,016	-69,172	93,844	68.00
69.00	06900	ELECTROCARDIOLOGY	97,991	2,440	100,431	55,247	155,678	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	523,310	523,310	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	606,841	606,841	0	606,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	541,638	4,702,147	5,243,785	-4,198	5,239,587	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,517,607	71,322	1,588,929	572,239	2,161,168	88.00
90.00	09000	CLINIC	782,196	65,578	847,774	8,512	856,286	90.00
90.01	09001	SURGICAL ASSOCIATES	57,672	551,189	608,861	14,660	623,521	90.01
90.02	09002	ORTHOPAEDICS	416,634	204,744	621,378	13,103	634,481	90.02
90.03	09003	RHEUMATOLOGY	534,335	6,880	541,215	14,846	556,061	90.03
90.04	09004	SPECIALTY CLINIC	708,703	110,561	819,264	-21,924	797,340	90.04
90.05	09005	PEDIATRICS	452,116	6,312	458,428	15,066	473,494	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	313,122	120,333	433,455	15,018	448,473	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	986,167	1,293,378	2,279,545	-38,381	2,241,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	105,547	26,660	132,207	-487	131,720	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,579,880	26,696,363	44,276,243	0	44,276,243	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	63,618	0	63,618	0	63,618	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	17,643,498	26,696,363	44,339,861	0	44,339,861	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-142,172	2,136,053	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-197,065	4,431,842	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,772,154	4,555,298	5.00
7.00	00700	OPERATION OF PLANT	-420	1,116,300	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,803	8.00
9.00	00900	HOUSEKEEPING	-92	739,312	9.00
10.00	01000	DIETARY	-740	139,489	10.00
11.00	01100	CAFETERIA	-83,819	244,515	11.00
13.00	01300	NURSING ADMINISTRATION	-407	187,431	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	134,521	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25	386,507	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-136,772	1,085,579	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-811,219	535,052	50.00
51.00	05100	RECOVERY ROOM	0	57,086	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-692,967	931,572	54.00
54.01	05401	ONCOLOGY	-250,000	362,045	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	-1,268	1,838,268	60.00
65.00	06500	RESPIRATORY THERAPY	0	152,306	65.00
66.00	06600	PHYSICAL THERAPY	0	308,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	204,680	67.00
68.00	06800	SPEECH PATHOLOGY	0	93,844	68.00
69.00	06900	ELECTROCARDIOLOGY	-6	155,672	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-8,011	515,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	606,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-38,495	5,201,092	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	2,161,168	88.00
90.00	09000	CLINIC	-503,074	353,212	90.00
90.01	09001	SURGICAL ASSOCIATES	-561,372	62,149	90.01
90.02	09002	ORTHOPAEDICS	-698,652	-64,171	90.02
90.03	09003	RHEUMATOLOGY	-625,086	-69,025	90.03
90.04	09004	SPECIALTY CLINIC	-604,853	192,487	90.04
90.05	09005	PEDIATRICS	-438,926	34,568	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	-505,405	-56,932	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	-3	2,241,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-3,915	127,805	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,076,918	31,199,325	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	63,618	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,076,918	31,262,943	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	246,800	81,534	1.00
	0		246,800	81,534	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	523,310	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	523,310	
	E - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	14,745	0	1.00
2.00	OPERATION OF PLANT	7.00	36,862	0	2.00
3.00	HOUSEKEEPING	9.00	36,862	0	3.00
4.00	DIETARY	10.00	29,490	0	4.00
5.00	RECOVERY ROOM	51.00	51,234	0	5.00
6.00	PHYSICAL THERAPY	66.00	34,586	0	6.00
7.00	OCCUPATIONAL THERAPY	67.00	34,586	0	7.00
	0		238,365	0	
	F - PHYSICIAN RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	680,494	0	1.00
	0		680,494	0	
	G - PHYSICIAN PRACTICE ADMIN RECLASS				
1.00	CLINIC	90.00	10,523	0	1.00
2.00	SURGICAL ASSOCIATES	90.01	15,127	0	2.00
3.00	ORTHOPAEDICS	90.02	15,127	0	3.00
4.00	RHEUMATOLOGY	90.03	15,127	0	4.00
5.00	SPECIALTY CLINIC	90.04	30,254	0	5.00
6.00	PEDIATRICS	90.05	15,127	0	6.00
7.00	PAIN MANAGEMENT	90.07	15,127	0	7.00
	0		116,412	0	
	H - RECLASS RHC EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	8,377	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		8,377	0	
	I - ECHO EXPENSE RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	0	55,340	1.00
	TOTALS		0	55,340	
500.00	Grand Total: Increases		1,290,448	660,184	500.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/27/2021 7:43 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - DIETARY/ CAFETERIA					
1.00	DIETARY	10.00	246,800	81,534	0	1.00
	0		246,800	81,534		
	C - MED SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	60	0	2.00
3.00	OPERATION OF PLANT	7.00	0	5	0	3.00
4.00	HOUSEKEEPING	9.00	0	24	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	482	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	25,884	0	6.00
7.00	OPERATING ROOM	50.00	0	379,414	0	7.00
8.00	RECOVERY ROOM	51.00	0	6,099	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,811	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,770	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	1,734	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	3	0	12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	70	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	93	0	14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,198	0	15.00
16.00	RURAL HEALTH CLINIC	88.00	0	220	0	16.00
17.00	CLINIC	90.00	0	1,478	0	17.00
18.00	SURGICAL ASSOCIATES	90.01	0	467	0	18.00
19.00	ORTHOPAEDICS	90.02	0	2,024	0	19.00
20.00	RHEUMATOLOGY	90.03	0	281	0	20.00
21.00	SPECIALTY CLINIC	90.04	0	52,178	0	21.00
22.00	PEDIATRICS	90.05	0	36	0	22.00
23.00	PAIN MANAGEMENT	90.07	0	109	0	23.00
24.00	EMERGENCY	91.00	0	38,381	0	24.00
25.00	AMBULANCE SERVICES	95.00	0	487	0	25.00
	0		0	523,310		
	E - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	117,959	0	0	1.00
2.00	OPERATING ROOM	50.00	41,444	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	69,172	0	0	3.00
4.00	RESPIRATORY THERAPY	65.00	9,790	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
	0		238,365	0		
	F - PHYSICIAN RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	680,494	0	0	1.00
	0		680,494	0		
	G - PHYSICIAN PRACTICE ADMIN RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	116,412	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
	0		116,412	0		
	H - RECLASS RHC EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	7,819	0	0	1.00
2.00	CLINIC	90.00	533	0	0	2.00
3.00	PEDIATRICS	90.05	25	0	0	3.00
	TOTALS		8,377	0		
	I - ECHO EXPENSE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	55,340	0	1.00
	TOTALS		0	55,340		
500.00	Grand Total: Decreases		1,290,448	660,184		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I Date/Time Prepared: 7/27/2021 7:43 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	188,708	0	0	0	0	1.00
2.00	Land Improvements	476,648	9,900	0	9,900	0	2.00
3.00	Buildings and Fixtures	18,721,469	398,864	0	398,864	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,652,653	2,169,479	0	2,169,479	751,075	5.00
6.00	Movable Equipment	17,127,188	1,239,034	0	1,239,034	34,553	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,166,666	3,817,277	0	3,817,277	785,628	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,166,666	3,817,277	0	3,817,277	785,628	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	188,708	0	1.00
2.00	Land Improvements	486,548	0	2.00
3.00	Buildings and Fixtures	19,120,333	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,071,057	0	5.00
6.00	Movable Equipment	18,331,669	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,198,315	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	42,198,315	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 7/27/2021 7:43 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,878,826	0	142,404	256,995	0	1.00
3.00	Total (sum of lines 1-2)	1,878,826	0	142,404	256,995	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,278,225	1.00
3.00	Total (sum of lines 1-2)	0	2,278,225	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/27/2021 7:43 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	42,198,314	0	42,198,314	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	42,198,314	0	42,198,314	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,876,272	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,876,272	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,786	256,995	0	0	2,136,053	1.00
3.00	Total (sum of lines 1-2)	2,786	256,995	0	0	2,136,053	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/27/2021 7:43 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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	-5,702,747			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
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
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/27/2021 7:43 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-2,554	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA	B	-83,819	CAFETERIA	11.00	0	33.00
33.01	JAIL MEALS	B	0	CAFETERIA	11.00	0	33.01
33.02	VENDING MACHINES	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	SALE OF DRUGS	B	-1,305	DRUGS CHARGED TO PATIENTS	73.00	0	33.03
33.04	SALE OF SUPPLIES	B	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.04
33.05	SALE OF PODIATRY SUPPLIES	B	-8,011	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.05
33.06	PHYSICIAN APPLICATION FEES	B	-2,165	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	NSF FEES	B	-130	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	MEDICAL RECORDS TRANSCRIPTION FEES	B	-25	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	COPIER FEES	B	-4,487	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ATHLETIC TRAINER - SCHOOL REV	B	-6,017	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OCCUPATIONAL HEALTH	B	-65,207	CLINIC	90.00	0	33.11
33.12	SALE OF SCRAP	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	SHUTTLE BUS SERVICES	B	-3,915	AMBULANCE SERVICES	95.00	0	33.13
33.14	MISC. INCOME	B	-296	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MISC. INCOME	B	-57,656	RHEUMATOLOGY	90.03	0	33.15
33.16	INTEREST INCOME	B	-139,618	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.16
33.17	TELEPHONE SALARY	A	-5,607	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	TELEPHONE OTHER	A	-1,266	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	TELEPHONE BENEFITS	A	-890	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	ADVERTISING	A	-196,935	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	IHA & AHA LOBBYING	A	-4,200	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	REBATES	B	-1,550	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	REBATES	B	-281	OPERATION OF PLANT	7.00	0	33.23
33.24	REBATES	B	-92	HOUSEKEEPING	9.00	0	33.24
33.25	REBATES	B	-740	DIETARY	10.00	0	33.25
33.26	REBATES	B	-407	NURSING ADMINISTRATION	13.00	0	33.26
33.27	REBATES	B	-2,094	OPERATING ROOM	50.00	0	33.27
33.28	REBATES	B	-400	RADIOLOGY-DIAGNOSTIC	54.00	0	33.28
33.29	REBATES	B	-1,268	LABORATORY	60.00	0	33.29
33.30	REBATES	B	-6	ELECTROCARDIOLOGY	69.00	0	33.30
33.31	REBATES	B	-37,190	DRUGS CHARGED TO PATIENTS	73.00	0	33.31
33.32	HAF EXPENSE	A	-1,279,092	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	PHYSICIAN RECRUITMENTS	A	-56,406	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	BAD DEBTS	A	-5,348,792	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	MISC. INCOME	A	-139	OPERATION OF PLANT	7.00	0	33.35
33.36	MISC. INCOME	A	-222	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	ADVERTISING	A	-61,386	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	REBATES	A	-3	EMERGENCY	91.00	0	33.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,076,918				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/27/2021 7:43 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	136,550	136,550	0	0	0	1.00
2.00	50.00	OPERATING ROOM	815,149	809,125	6,024	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	706,619	692,567	14,052	0	0	3.00
4.00	54.01	ONCOLOGY	250,000	250,000	0	0	0	4.00
5.00	60.00	LABORATORY	38,400	0	38,400	0	0	5.00
6.00	90.00	CLINIC	466,046	437,867	28,179	0	0	6.00
7.00	90.01	SURGICAL ASSOCIATES	569,088	561,372	7,716	0	0	7.00
8.00	90.02	ORTHOPAEDICS	715,173	698,652	16,521	0	0	8.00
9.00	90.03	RHEUMATOLOGY	589,834	567,430	22,404	0	0	9.00
10.00	90.04	SPECIALTY CLINIC	631,246	604,853	26,393	0	0	10.00
11.00	90.05	PEDIATRICS	450,729	438,926	11,803	0	0	11.00
12.00	90.07	PAIN MANAGEMENT	510,558	505,405	5,153	0	0	12.00
13.00	91.00	EMERGENCY	1,166,867	0	1,166,867	0	0	13.00
200.00			7,046,259	5,702,747	1,343,512		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.01	ONCOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	7.00
8.00	90.02	ORTHOPAEDICS	0	0	0	0	0	8.00
9.00	90.03	RHEUMATOLOGY	0	0	0	0	0	9.00
10.00	90.04	SPECIALTY CLINIC	0	0	0	0	0	10.00
11.00	90.05	PEDIATRICS	0	0	0	0	0	11.00
12.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
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	136,550	1.00
2.00	50.00	OPERATING ROOM	0	0	0	809,125	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	692,567	3.00
4.00	54.01	ONCOLOGY	0	0	0	250,000	4.00
5.00	60.00	LABORATORY	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	437,867	6.00
7.00	90.01	SURGICAL ASSOCIATES	0	0	0	561,372	7.00
8.00	90.02	ORTHOPAEDICS	0	0	0	698,652	8.00
9.00	90.03	RHEUMATOLOGY	0	0	0	567,430	9.00
10.00	90.04	SPECIALTY CLINIC	0	0	0	604,853	10.00
11.00	90.05	PEDIATRICS	0	0	0	438,926	11.00
12.00	90.07	PAIN MANAGEMENT	0	0	0	505,405	12.00
13.00	91.00	EMERGENCY	0	0	0	0	13.00
200.00			0	0	0	5,702,747	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,136,053	2,136,053				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,431,842	81,943	4,513,785			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,555,298	157,971	774,901	5,488,170	5,488,170	5.00
7.00	00700	OPERATION OF PLANT	1,116,300	253,515	93,916	1,463,731	311,669	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,803	12,953	0	110,756	23,583	8.00
9.00	00900	HOUSEKEEPING	739,312	51,576	149,568	940,456	200,249	9.00
10.00	01000	DIETARY	139,489	79,192	29,509	248,190	52,847	10.00
11.00	01100	CAFETERIA	244,515	18,181	64,604	327,300	69,691	11.00
13.00	01300	NURSING ADMINISTRATION	187,431	2,398	45,445	235,274	50,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,521	47,822	18,206	200,549	42,702	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,507	83,378	83,031	552,916	117,731	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,085,579	161,686	289,824	1,537,089	327,289	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	535,052	134,305	301,681	971,038	206,761	50.00
51.00	05100	RECOVERY ROOM	57,086	11,577	13,411	82,074	17,476	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	931,572	83,064	284,717	1,299,353	276,669	54.00
54.01	05401	ONCOLOGY	362,045	76,361	81,436	519,842	110,689	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,838,268	55,251	192,947	2,086,466	444,267	60.00
65.00	06500	RESPIRATORY THERAPY	152,306	2,752	32,093	187,151	39,850	65.00
66.00	06600	PHYSICAL THERAPY	308,496	38,839	79,369	426,704	90,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	204,680	16,963	52,914	274,557	58,461	67.00
68.00	06800	SPEECH PATHOLOGY	93,844	3,558	24,317	121,719	25,917	68.00
69.00	06900	ELECTROCARDIOLOGY	155,672	17,611	25,651	198,934	42,359	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	515,299	0	0	515,299	109,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	606,841	0	0	606,841	129,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,201,092	42,161	141,782	5,385,035	1,146,625	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,161,168	127,819	547,106	2,836,093	603,884	88.00
90.00	09000	CLINIC	353,212	169,489	207,367	730,068	155,452	90.00
90.01	09001	SURGICAL ASSOCIATES	62,149	32,549	19,056	113,754	24,221	90.01
90.02	09002	ORTHOPAEDICS	-64,171	20,245	113,020	69,094	14,712	90.02
90.03	09003	RHEUMATOLOGY	-69,025	44,539	143,830	119,344	25,412	90.03
90.04	09004	SPECIALTY CLINIC	192,487	62,642	193,433	448,562	95,511	90.04
90.05	09005	PEDIATRICS	34,568	66,023	122,301	222,892	47,460	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	-56,932	30,250	85,924	59,242	12,614	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,241,161	78,622	258,144	2,577,927	548,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	127,805	33,178	27,629	188,612	40,161	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,199,325	2,098,413	4,497,132	31,145,032	5,463,063	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	63,618	37,640	16,653	117,911	25,107	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	31,262,943	2,136,053	4,513,785	31,262,943	5,488,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,775,400					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,000	148,339				8.00
9.00	00900	HOUSEKEEPING	55,745	10,412	1,206,862			9.00
10.00	01000	DIETARY	85,593	4,269	60,563	451,462		10.00
11.00	01100	CAFETERIA	19,651	0	13,904	0	430,546	11.00
13.00	01300	NURSING ADMINISTRATION	2,592	0	1,834	0	3,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,687	0	36,572	0	4,763	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,118	0	63,764	0	22,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	174,755	96,724	123,650	451,462	43,340	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	145,162	9,709	102,711	0	28,576	50.00
51.00	05100	RECOVERY ROOM	12,513	0	8,854	0	2,143	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,778	6,273	63,524	0	29,052	54.00
54.01	05401	ONCOLOGY	82,534	0	58,398	0	13,574	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	59,717	0	42,254	0	35,482	60.00
65.00	06500	RESPIRATORY THERAPY	2,974	1,249	2,104	0	4,763	65.00
66.00	06600	PHYSICAL THERAPY	41,979	2,920	29,703	0	11,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,334	1,343	12,972	0	6,668	67.00
68.00	06800	SPEECH PATHOLOGY	3,845	57	2,721	0	2,858	68.00
69.00	06900	ELECTROCARDIOLOGY	19,035	0	13,468	0	4,763	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,569	0	32,243	0	15,479	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	138,151	0	97,751	0	64,055	88.00
90.00	09000	CLINIC	183,188	0	129,618	0	34,053	90.00
90.01	09001	SURGICAL ASSOCIATES	35,180	0	24,892	0	4,525	90.01
90.02	09002	ORTHOPAEDICS	21,882	0	15,483	0	2,858	90.02
90.03	09003	RHEUMATOLOGY	48,139	0	34,062	0	9,525	90.03
90.04	09004	SPECIALTY CLINIC	67,705	0	47,906	0	23,099	90.04
90.05	09005	PEDIATRICS	71,359	0	50,491	0	12,383	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	32,695	0	23,134	0	4,525	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	84,977	15,383	60,127	0	39,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	35,860	0	25,373	0	4,763	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,734,717	148,339	1,178,076	451,462	427,688	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	40,683	0	28,786	0	2,858	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	1,775,400	148,339	1,206,862	451,462	430,546	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	293,130					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	336,273				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	146	846,821			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,860	5,893	363,847	3,181,909	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,249	80,420	0	1,577,626	0	50.00
51.00	05100	RECOVERY ROOM	2,626	923	80,017	206,626	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,396	6,262	96,882	1,902,189	0	54.00
54.01	05401	ONCOLOGY	16,019	1,974	0	803,030	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	41,946	92,540	0	2,802,672	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,109	1,109	1,794	247,103	0	65.00
66.00	06600	PHYSICAL THERAPY	13,944	437	0	618,213	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,827	265	0	380,427	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,267	168	0	160,552	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,547	135	0	284,241	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,919	0	649,940	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	98,138	0	834,192	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,273	2,733	0	6,645,957	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,507	0	3,742,441	0	88.00
90.00	09000	CLINIC	0	4,972	0	1,237,351	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	62	0	202,634	0	90.01
90.02	09002	ORTHOPAEDICS	0	76	0	124,105	0	90.02
90.03	09003	RHEUMATOLOGY	0	126	0	236,608	0	90.03
90.04	09004	SPECIALTY CLINIC	0	2,915	0	685,698	0	90.04
90.05	09005	PEDIATRICS	0	807	0	405,392	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	420	0	132,630	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	46,554	7,912	304,281	3,685,366	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,513	414	0	300,696	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,130	336,273	846,821	31,047,598	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	215,345	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	293,130	336,273	846,821	31,262,943	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	3,181,909	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,577,626	50.00
51.00	05100	RECOVERY ROOM	206,626	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,902,189	54.00
54.01	05401	ONCOLOGY	803,030	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	2,802,672	60.00
65.00	06500	RESPIRATORY THERAPY	247,103	65.00
66.00	06600	PHYSICAL THERAPY	618,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,427	67.00
68.00	06800	SPEECH PATHOLOGY	160,552	68.00
69.00	06900	ELECTROCARDIOLOGY	284,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	649,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	834,192	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,645,957	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	3,742,441	88.00
90.00	09000	CLINIC	1,237,351	90.00
90.01	09001	SURGICAL ASSOCIATES	202,634	90.01
90.02	09002	ORTHOPAEDICS	124,105	90.02
90.03	09003	RHEUMATOLOGY	236,608	90.03
90.04	09004	SPECIALTY CLINIC	685,698	90.04
90.05	09005	PEDIATRICS	405,392	90.05
90.06	09006	WOMEN'S HEALTH	0	90.06
90.07	09007	PAIN MANAGEMENT	132,630	90.07
90.08	09008	ONCOLOGY MD	0	90.08
91.00	09100	EMERGENCY	3,685,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	300,696	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,047,598	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	FOUNDATION	215,345	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	193.02
194.00	07950	NON REIMBURSABLE	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,262,943	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	81,943	81,943	81,943		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	157,971	157,971	14,067	172,038	5.00
7.00	00700	OPERATION OF PLANT	0	253,515	253,515	1,705	9,770	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,953	12,953	0	739	8.00
9.00	00900	HOUSEKEEPING	0	51,576	51,576	2,715	6,278	9.00
10.00	01000	DIETARY	0	79,192	79,192	536	1,657	10.00
11.00	01100	CAFETERIA	0	18,181	18,181	1,173	2,185	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,398	2,398	825	1,570	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,822	47,822	331	1,339	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	83,378	83,378	1,507	3,691	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	161,686	161,686	5,261	10,260	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	134,305	134,305	5,477	6,482	50.00
51.00	05100	RECOVERY ROOM	0	11,577	11,577	243	548	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,064	83,064	5,169	8,673	54.00
54.01	05401	ONCOLOGY	0	76,361	76,361	1,478	3,470	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	55,251	55,251	3,503	13,927	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,752	2,752	583	1,249	65.00
66.00	06600	PHYSICAL THERAPY	0	38,839	38,839	1,441	2,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,963	16,963	961	1,833	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,558	3,558	441	812	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,611	17,611	466	1,328	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,051	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,161	42,161	2,574	35,936	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	127,819	127,819	9,932	18,931	88.00
90.00	09000	CLINIC	0	169,489	169,489	3,764	4,873	90.00
90.01	09001	SURGICAL ASSOCIATES	0	32,549	32,549	346	759	90.01
90.02	09002	ORTHOPAEDICS	0	20,245	20,245	2,052	461	90.02
90.03	09003	RHEUMATOLOGY	0	44,539	44,539	2,611	797	90.03
90.04	09004	SPECIALTY CLINIC	0	62,642	62,642	3,512	2,994	90.04
90.05	09005	PEDIATRICS	0	66,023	66,023	2,220	1,488	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	30,250	30,250	1,560	395	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	78,622	78,622	4,686	17,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	33,178	33,178	502	1,259	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,098,413	2,098,413	81,641	171,251	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	37,640	37,640	302	787	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	0	2,136,053	2,136,053	81,943	172,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	264,990					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,090	15,782				8.00
9.00	00900	HOUSEKEEPING	8,320	1,108	69,997			9.00
10.00	01000	DIETARY	12,775	454	3,513	98,127		10.00
11.00	01100	CAFETERIA	2,933	0	806	0	25,278	11.00
13.00	01300	NURSING ADMINISTRATION	387	0	106	0	196	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,715	0	2,121	0	280	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,451	0	3,698	0	1,300	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,083	10,290	7,172	98,127	2,545	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,666	1,033	5,957	0	1,678	50.00
51.00	05100	RECOVERY ROOM	1,868	0	514	0	126	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,400	667	3,684	0	1,706	54.00
54.01	05401	ONCOLOGY	12,319	0	3,387	0	797	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	8,913	0	2,451	0	2,083	60.00
65.00	06500	RESPIRATORY THERAPY	444	133	122	0	280	65.00
66.00	06600	PHYSICAL THERAPY	6,266	311	1,723	0	685	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,736	143	752	0	391	67.00
68.00	06800	SPEECH PATHOLOGY	574	6	158	0	168	68.00
69.00	06900	ELECTROCARDIOLOGY	2,841	0	781	0	280	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,801	0	1,870	0	909	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,620	0	5,669	0	3,758	88.00
90.00	09000	CLINIC	27,343	0	7,517	0	1,999	90.00
90.01	09001	SURGICAL ASSOCIATES	5,251	0	1,444	0	266	90.01
90.02	09002	ORTHOPAEDICS	3,266	0	898	0	168	90.02
90.03	09003	RHEUMATOLOGY	7,185	0	1,976	0	559	90.03
90.04	09004	SPECIALTY CLINIC	10,105	0	2,779	0	1,356	90.04
90.05	09005	PEDIATRICS	10,651	0	2,928	0	727	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4,880	0	1,342	0	266	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	12,683	1,637	3,487	0	2,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,352	0	1,472	0	280	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,918	15,782	68,327	98,127	25,110	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	6,072	0	1,670	0	168	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	264,990	15,782	69,997	98,127	25,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,482					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,608				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26	107,051			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,082	1,045	45,996	369,547	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	622	14,255	0	191,475	0	50.00
51.00	05100	RECOVERY ROOM	49	164	10,115	25,204	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	643	1,110	12,247	130,363	0	54.00
54.01	05401	ONCOLOGY	300	350	0	98,462	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	784	16,404	0	103,316	0	60.00
65.00	06500	RESPIRATORY THERAPY	114	197	227	6,101	0	65.00
66.00	06600	PHYSICAL THERAPY	261	77	0	52,451	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	146	47	0	23,972	0	67.00
68.00	06800	SPEECH PATHOLOGY	61	30	0	5,808	0	68.00
69.00	06900	ELECTROCARDIOLOGY	104	24	0	23,435	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,417	0	7,857	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,397	0	21,448	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	342	484	0	91,077	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	444	0	187,173	0	88.00
90.00	09000	CLINIC	0	881	0	215,866	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	11	0	40,626	0	90.01
90.02	09002	ORTHOPAEDICS	0	14	0	27,104	0	90.02
90.03	09003	RHEUMATOLOGY	0	22	0	57,689	0	90.03
90.04	09004	SPECIALTY CLINIC	0	517	0	83,905	0	90.04
90.05	09005	PEDIATRICS	0	143	0	84,180	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	74	0	38,767	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	871	1,402	38,466	161,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	103	73	0	42,219	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,482	59,608	107,051	2,089,414	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	46,639	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	5,482	59,608	107,051	2,136,053	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	369,547	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	191,475	50.00
51.00	05100	RECOVERY ROOM	25,204	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,363	54.00
54.01	05401	ONCOLOGY	98,462	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	103,316	60.00
65.00	06500	RESPIRATORY THERAPY	6,101	65.00
66.00	06600	PHYSICAL THERAPY	52,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,972	67.00
68.00	06800	SPEECH PATHOLOGY	5,808	68.00
69.00	06900	ELECTROCARDIOLOGY	23,435	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,857	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,077	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	187,173	88.00
90.00	09000	CLINIC	215,866	90.00
90.01	09001	SURGICAL ASSOCIATES	40,626	90.01
90.02	09002	ORTHOPAEDICS	27,104	90.02
90.03	09003	RHEUMATOLOGY	57,689	90.03
90.04	09004	SPECIALTY CLINIC	83,905	90.04
90.05	09005	PEDIATRICS	84,180	90.05
90.06	09006	WOMEN'S HEALTH	0	90.06
90.07	09007	PAIN MANAGEMENT	38,767	90.07
90.08	09008	ONCOLOGY MD	0	90.08
91.00	09100	EMERGENCY	161,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	42,219	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,089,414	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	FOUNDATION	46,639	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	193.02
194.00	07950	NON REIMBURSABLE	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,136,053	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	108,675					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,169	17,243,642				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,037	2,960,289	-5,488,170	25,774,773		5.00
7.00	00700	OPERATION OF PLANT	12,898	358,780	0	1,463,731	83,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	659	0	0	110,756	659	8.00
9.00	00900	HOUSEKEEPING	2,624	571,381	0	940,456	2,624	9.00
10.00	01000	DIETARY	4,029	112,729	0	248,190	4,029	10.00
11.00	01100	CAFETERIA	925	246,800	0	327,300	925	11.00
13.00	01300	NURSING ADMINISTRATION	122	173,611	0	235,274	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,433	69,550	0	200,549	2,433	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,242	317,195	0	552,916	4,242	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,226	1,107,192	0	1,537,089	8,226	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,833	1,152,488	0	971,038	6,833	50.00
51.00	05100	RECOVERY ROOM	589	51,234	0	82,074	589	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,226	1,087,681	0	1,299,353	4,226	54.00
54.01	05401	ONCOLOGY	3,885	311,102	0	519,842	3,885	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,811	737,101	0	2,086,466	2,811	60.00
65.00	06500	RESPIRATORY THERAPY	140	122,603	0	187,151	140	65.00
66.00	06600	PHYSICAL THERAPY	1,976	303,208	0	426,704	1,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	202,144	0	274,557	863	67.00
68.00	06800	SPEECH PATHOLOGY	181	92,895	0	121,719	181	68.00
69.00	06900	ELECTROCARDIOLOGY	896	97,991	0	198,934	896	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	515,299	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	606,841	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,145	541,638	0	5,385,035	2,145	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,503	2,090,066	0	2,836,093	6,503	88.00
90.00	09000	CLINIC	8,623	792,186	0	730,068	8,623	90.00
90.01	09001	SURGICAL ASSOCIATES	1,656	72,799	0	113,754	1,656	90.01
90.02	09002	ORTHOPAEDICS	1,030	431,761	0	69,094	1,030	90.02
90.03	09003	RHEUMATOLOGY	2,266	549,462	0	119,344	2,266	90.03
90.04	09004	SPECIALTY CLINIC	3,187	738,957	0	448,562	3,187	90.04
90.05	09005	PEDIATRICS	3,359	467,218	0	222,892	3,359	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	1,539	328,249	0	59,242	1,539	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	4,000	986,167	0	2,577,927	4,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,688	105,547	0	188,612	1,688	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,760	17,180,024	-5,488,170	25,656,862	81,656	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	1,915	63,618	0	117,911	1,915	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	2,136,053	4,513,785		5,488,170	1,775,400	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.655422	0.261765		0.212928	21.244212	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		81,943		172,038	264,990	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004752		0.006675	3.170837	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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	80,288				9.00
10.00	01000	DIETARY	820	4,029	100			10.00
11.00	01100	CAFETERIA	0	925	0	1,808		11.00
13.00	01300	NURSING ADMINISTRATION	0	122	0	14	215,910	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,433	0	20	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,242	0	93	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,580	8,226	100	182	42,618	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	6,833	0	120	24,490	50.00
51.00	05100	RECOVERY ROOM	0	589	0	9	1,934	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	4,226	0	122	25,335	54.00
54.01	05401	ONCOLOGY	0	3,885	0	57	11,799	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,811	0	149	30,896	60.00
65.00	06500	RESPIRATORY THERAPY	240	140	0	20	4,500	65.00
66.00	06600	PHYSICAL THERAPY	561	1,976	0	49	10,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	863	0	28	5,765	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	12	2,406	68.00
69.00	06900	ELECTROCARDIOLOGY	0	896	0	20	4,086	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,145	0	65	13,459	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,503	0	269	0	88.00
90.00	09000	CLINIC	0	8,623	0	143	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,656	0	19	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,030	0	12	0	90.02
90.03	09003	RHEUMATOLOGY	0	2,266	0	40	0	90.03
90.04	09004	SPECIALTY CLINIC	0	3,187	0	97	0	90.04
90.05	09005	PEDIATRICS	0	3,359	0	52	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	1,539	0	19	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,955	4,000	0	165	34,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,688	0	20	4,061	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	78,373	100	1,796	215,910	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	1,915	0	12	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
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)	148,339	1,206,862	451,462	430,546	293,130	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.205790	15.031661	4,514.620000	238.133850	1.357649	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,782	69,997	98,127	25,278	5,482	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.553852	0.871824	981.270000	13.981195	0.025390	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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/27/2021 7:43 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			14.00	16.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,079,344		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	901	94,400	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	36,437	40,560	30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	497,274	0	50.00
51.00	05100	RECOVERY ROOM	5,705	8,920	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,722	10,800	54.00
54.01	05401	ONCOLOGY	12,205	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	572,223	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,858	200	65.00
66.00	06600	PHYSICAL THERAPY	2,700	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,640	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,037	0	68.00
69.00	06900	ELECTROCARDIOLOGY	835	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,087	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	606,841	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,898	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	15,505	0	88.00
90.00	09000	CLINIC	30,745	0	90.00
90.01	09001	SURGICAL ASSOCIATES	384	0	90.01
90.02	09002	ORTHOPAEDICS	471	0	90.02
90.03	09003	RHEUMATOLOGY	777	0	90.03
90.04	09004	SPECIALTY CLINIC	18,026	0	90.04
90.05	09005	PEDIATRICS	4,992	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	2,596	0	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	48,923	33,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	2,562	0	95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,079,344	94,400	118.00
	NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
194.00	07950	NON REIMBURSABLE	0	0	194.00
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)	336,273	846,821	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.161721	8.970561	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,608	107,051	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028667	1.134015	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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,181,909		3,181,909	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,577,626		1,577,626	0	0	50.00
51.00	05100	RECOVERY ROOM	206,626		206,626	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,902,189		1,902,189	0	0	54.00
54.01	05401	ONCOLOGY	803,030		803,030	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,802,672		2,802,672	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	247,103	0	247,103	0	0	65.00
66.00	06600	PHYSICAL THERAPY	618,213	0	618,213	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,427	0	380,427	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	160,552	0	160,552	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	284,241		284,241	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	649,940		649,940	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	834,192		834,192	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,645,957		6,645,957	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,742,441		3,742,441	0	0	88.00
90.00	09000	CLINIC	1,237,351		1,237,351	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	202,634		202,634	0	0	90.01
90.02	09002	ORTHOPAEDICS	124,105		124,105	0	0	90.02
90.03	09003	RHEUMATOLOGY	236,608		236,608	0	0	90.03
90.04	09004	SPECIALTY CLINIC	685,698		685,698	0	0	90.04
90.05	09005	PEDIATRICS	405,392		405,392	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0		0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	132,630		132,630	0	0	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	3,685,366		3,685,366	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,135,063		1,135,063		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	300,696		300,696	0	0	95.00
200.00		Subtotal (see instructions)	32,182,661	0	32,182,661	0	0	200.00
201.00		Less Observation Beds	1,135,063		1,135,063		0	201.00
202.00		Total (see instructions)	31,047,598	0	31,047,598	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,323,330		3,323,330			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	290,896	5,616,041	5,906,937	0.267080	0.000000	50.00
51.00	05100	RECOVERY ROOM	83,308	1,936,550	2,019,858	0.102297	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	732,944	23,332,479	24,065,423	0.079042	0.000000	54.00
54.01	05401	ONCOLOGY	0	516,146	516,146	1.555819	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	764,436	10,741,781	11,506,217	0.243579	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	133,643	162,370	296,013	0.834771	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	289,478	1,861,181	2,150,659	0.287453	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,367	1,733,042	1,920,409	0.198097	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	61,814	354,466	416,280	0.385683	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	253,701	3,487,637	3,741,338	0.075973	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	194,292	4,237,707	4,431,999	0.146647	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	117,879	2,770,440	2,888,319	0.288816	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734,461	16,401,618	17,136,079	0.387834	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,454	830,349	833,803			88.00
90.00	09000	CLINIC	0	195,914	195,914	6.315787	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	7,489	7,489	27.057551	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	190,690	190,690	0.650821	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	97,121	97,121	2.436219	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	295,827	295,827	2.317902	0.000000	90.04
90.05	09005	PEDIATRICS	181	184,142	184,323	2.199357	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	29,304	29,304	4.526003	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	62,601	5,861,890	5,924,491	0.622056	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,588	1,143,043	1,157,631	0.980505	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	749,288	749,288	0.401309	0.000000	95.00
200.00		Subtotal (see instructions)	7,248,373	82,736,515	89,984,888			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,248,373	82,736,515	89,984,888			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
90.08	09008	ONCOLOGY MD	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 7:43 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,181,909		3,181,909	0	3,181,909	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,577,626		1,577,626	0	1,577,626	50.00
51.00	05100	RECOVERY ROOM	206,626		206,626	0	206,626	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,902,189		1,902,189	0	1,902,189	54.00
54.01	05401	ONCOLOGY	803,030		803,030	0	803,030	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,802,672		2,802,672	0	2,802,672	60.00
65.00	06500	RESPIRATORY THERAPY	247,103	0	247,103	0	247,103	65.00
66.00	06600	PHYSICAL THERAPY	618,213	0	618,213	0	618,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,427	0	380,427	0	380,427	67.00
68.00	06800	SPEECH PATHOLOGY	160,552	0	160,552	0	160,552	68.00
69.00	06900	ELECTROCARDIOLOGY	284,241		284,241	0	284,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	649,940		649,940	0	649,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	834,192		834,192	0	834,192	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,645,957		6,645,957	0	6,645,957	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,742,441		3,742,441	0	3,742,441	88.00
90.00	09000	CLINIC	1,237,351		1,237,351	0	1,237,351	90.00
90.01	09001	SURGICAL ASSOCIATES	202,634		202,634	0	202,634	90.01
90.02	09002	ORTHOPAEDICS	124,105		124,105	0	124,105	90.02
90.03	09003	RHEUMATOLOGY	236,608		236,608	0	236,608	90.03
90.04	09004	SPECIALTY CLINIC	685,698		685,698	0	685,698	90.04
90.05	09005	PEDIATRICS	405,392		405,392	0	405,392	90.05
90.06	09006	WOMEN'S HEALTH	0		0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	132,630		132,630	0	132,630	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	3,685,366		3,685,366	0	3,685,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,135,063		1,135,063		1,135,063	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	300,696		300,696	0	300,696	95.00
200.00		Subtotal (see instructions)	32,182,661	0	32,182,661	0	32,182,661	200.00
201.00		Less Observation Beds	1,135,063		1,135,063		1,135,063	201.00
202.00		Total (see instructions)	31,047,598	0	31,047,598	0	31,047,598	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/27/2021 7:43 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,323,330		3,323,330			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	290,896	5,616,041	5,906,937	0.267080	0.000000	50.00
51.00	05100	RECOVERY ROOM	83,308	1,936,550	2,019,858	0.102297	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	732,944	23,332,479	24,065,423	0.079042	0.000000	54.00
54.01	05401	ONCOLOGY	0	516,146	516,146	1.555819	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	764,436	10,741,781	11,506,217	0.243579	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	133,643	162,370	296,013	0.834771	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	289,478	1,861,181	2,150,659	0.287453	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,367	1,733,042	1,920,409	0.198097	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	61,814	354,466	416,280	0.385683	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	253,701	3,487,637	3,741,338	0.075973	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	194,292	4,237,707	4,431,999	0.146647	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	117,879	2,770,440	2,888,319	0.288816	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734,461	16,401,618	17,136,079	0.387834	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,454	830,349	833,803	4.488400	0.000000	88.00
90.00	09000	CLINIC	0	195,914	195,914	6.315787	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	7,489	7,489	27.057551	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	190,690	190,690	0.650821	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	97,121	97,121	2.436219	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	295,827	295,827	2.317902	0.000000	90.04
90.05	09005	PEDIATRICS	181	184,142	184,323	2.199357	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	29,304	29,304	4.526003	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	62,601	5,861,890	5,924,491	0.622056	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,588	1,143,043	1,157,631	0.980505	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	749,288	749,288	0.401309	0.000000	95.00
200.00		Subtotal (see instructions)	7,248,373	82,736,515	89,984,888			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,248,373	82,736,515	89,984,888			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 7:43 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
90.08	09008	ONCOLOGY MD	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	191,475	5,906,937	0.032415	122,293	3,964	50.00
51.00	05100	RECOVERY ROOM	25,204	2,019,858	0.012478	30,590	382	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,363	24,065,423	0.005417	384,210	2,081	54.00
54.01	05401	ONCOLOGY	98,462	516,146	0.190764	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	103,316	11,506,217	0.008979	421,639	3,786	60.00
65.00	06500	RESPIRATORY THERAPY	6,101	296,013	0.020611	73,713	1,519	65.00
66.00	06600	PHYSICAL THERAPY	52,451	2,150,659	0.024388	143,093	3,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,972	1,920,409	0.012483	94,825	1,184	67.00
68.00	06800	SPEECH PATHOLOGY	5,808	416,280	0.013952	36,859	514	68.00
69.00	06900	ELECTROCARDIOLOGY	23,435	3,741,338	0.006264	141,907	889	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,857	4,431,999	0.001773	26,404	47	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,448	2,888,319	0.007426	43,909	326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,077	17,136,079	0.005315	385,107	2,047	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	187,173	833,803	0.224481	0	0	88.00
90.00	09000	CLINIC	215,866	195,914	1.101841	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	40,626	7,489	5.424756	0	0	90.01
90.02	09002	ORTHOPAEDICS	27,104	190,690	0.142136	0	0	90.02
90.03	09003	RHEUMATOLOGY	57,689	97,121	0.593991	0	0	90.03
90.04	09004	SPECIALTY CLINIC	83,905	295,827	0.283629	0	0	90.04
90.05	09005	PEDIATRICS	84,180	184,323	0.456698	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	38,767	29,304	1.322925	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0.000000	0	0	90.08
91.00	09100	EMERGENCY	161,369	5,924,491	0.027238	556	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	131,826	1,157,631	0.113876	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,809,474	85,912,270		1,905,105	20,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304

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

Worksheet D Part IV

Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,906,937	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,019,858	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,065,423	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	516,146	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	11,506,217	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	296,013	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,150,659	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,920,409	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	416,280	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,741,338	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,431,999	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,888,319	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,136,079	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	833,803	0.000000	88.00
90.00	09000	CLINIC	0	0	0	195,914	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	7,489	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	190,690	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	97,121	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	295,827	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	184,323	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	29,304	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	5,924,491	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,157,631	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	85,912,270		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	122,293	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	30,590	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	384,210	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	421,639	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	73,713	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	143,093	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	94,825	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	36,859	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	141,907	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	26,404	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	43,909	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	385,107	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	556	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,905,105	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.267080	0	2,343,198	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102297	0	414,803	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079042	0	6,306,759	0	0	54.00
54.01	05401	ONCOLOGY	1.555819	0	287,067	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.243579	0	3,122,965	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.834771	0	43,053	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.287453	0	617,968	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198097	0	366,123	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.385683	0	43,616	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075973	0	1,357,739	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146647	0	74,891	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.288816	0	821,317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387834	0	9,381,474	12,084	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	6.315787	0	41,361	244	0	90.00
90.01	09001	SURGICAL ASSOCIATES	27.057551	0	7,488	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.650821	0	35,469	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.436219	0	55,112	370	0	90.03
90.04	09004	SPECIALTY CLINIC	2.317902	0	168,141	9	0	90.04
90.05	09005	PEDIATRICS	2.199357	0	2,216	17	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.526003	0	15,058	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.622056	0	1,170,263	2,114	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980505	0	375,964	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.401309		0			95.00
200.00		Subtotal (see instructions)		0	27,052,045	14,838	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	27,052,045	14,838	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	625,821	0	50.00
51.00	05100	RECOVERY ROOM	42,433	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,499	0	54.00
54.01	05401	ONCOLOGY	446,624	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	760,689	0	60.00
65.00	06500	RESPIRATORY THERAPY	35,939	0	65.00
66.00	06600	PHYSICAL THERAPY	177,637	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,528	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,822	0	68.00
69.00	06900	ELECTROCARDIOLOGY	103,152	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,983	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	237,209	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,638,455	4,687	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	261,227	1,541	90.00
90.01	09001	SURGICAL ASSOCIATES	202,607	0	90.01
90.02	09002	ORTHOPAEDICS	23,084	0	90.02
90.03	09003	RHEUMATOLOGY	134,265	901	90.03
90.04	09004	SPECIALTY CLINIC	389,734	21	90.04
90.05	09005	PEDIATRICS	4,874	37	90.05
90.06	09006	WOMEN'S HEALTH	0	0	90.06
90.07	09007	PAIN MANAGEMENT	68,153	0	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	727,969	1,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,635	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	8,847,339	8,502	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,847,339	8,502	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,865	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,765	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)	1,104	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	87	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	13	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)	693	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)	87	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,181,909	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)	1,679	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)	151,075	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,030,834	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)	3,030,834	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,717.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,190,013	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,190,013	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	481,568	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,671,581	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)	149,396	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)	149,396	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)	661	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,717.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,135,063	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	369,547	3,181,909	0.116140	1,135,063	131,826	90.00
91.00	Nursing School cost	0	3,181,909	0.000000	1,135,063	0	91.00
92.00	Allied health cost	0	3,181,909	0.000000	1,135,063	0	92.00
93.00	All other Medical Education	0	3,181,909	0.000000	1,135,063	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 7:43 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,865	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,765	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)	1,104	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	87	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	13	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)	33	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,181,909	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	149,474	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,032,435	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)	3,032,435	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,718.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	56,697	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)	56,697	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/27/2021 7:43 am
	Title XIX	Hospital	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	14,902	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	71,599	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)	661	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,718.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,135,657	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/27/2021 7:43 am
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	369,547	3,181,909	0.116140	1,135,657	131,895	90.00
91.00	Nursing School cost	0	3,181,909	0.000000	1,135,657	0	91.00
92.00	Allied health cost	0	3,181,909	0.000000	1,135,657	0	92.00
93.00	All other Medical Education	0	3,181,909	0.000000	1,135,657	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,210,641		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.267080	122,293	32,662	50.00
51.00	05100	RECOVERY ROOM	0.102297	30,590	3,129	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079042	384,210	30,369	54.00
54.01	05401	ONCOLOGY	1.555819	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.243579	421,639	102,702	60.00
65.00	06500	RESPIRATORY THERAPY	0.834771	73,713	61,533	65.00
66.00	06600	PHYSICAL THERAPY	0.287453	143,093	41,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198097	94,825	18,785	67.00
68.00	06800	SPEECH PATHOLOGY	0.385683	36,859	14,216	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075973	141,907	10,781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146647	26,404	3,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.288816	43,909	12,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387834	385,107	149,358	73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	6.315787	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	27.057551	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.650821	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.436219	0	0	90.03
90.04	09004	SPECIALTY CLINIC	2.317902	0	0	90.04
90.05	09005	PEDIATRICS	2.199357	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.526003	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.622056	556	346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980505	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,905,105	481,568	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,905,105		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.267080	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102297	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079042	2,297	182	54.00
54.01	05401	ONCOLOGY	1.555819	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.243579	9,769	2,380	60.00
65.00	06500	RESPIRATORY THERAPY	0.834771	2,154	1,798	65.00
66.00	06600	PHYSICAL THERAPY	0.287453	53,337	15,332	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198097	37,465	7,422	67.00
68.00	06800	SPEECH PATHOLOGY	0.385683	8,121	3,132	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075973	6,628	504	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146647	710	104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.288816	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387834	16,273	6,311	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	6.315787	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	27.057551	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.650821	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.436219	0	0	90.03
90.04	09004	SPECIALTY CLINIC	2.317902	0	0	90.04
90.05	09005	PEDIATRICS	2.199357	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.526003	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.622056	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980505	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		136,754	37,165	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)		136,754		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/27/2021 7:43 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		27,902		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.267080	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102297	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079042	27,856	2,202	54.00
54.01	05401	ONCOLOGY	1.555819	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.243579	16,292	3,968	60.00
65.00	06500	RESPIRATORY THERAPY	0.834771	594	496	65.00
66.00	06600	PHYSICAL THERAPY	0.287453	991	285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198097	1,169	232	67.00
68.00	06800	SPEECH PATHOLOGY	0.385683	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075973	1,250	95	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146647	69	10	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.288816	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387834	9,927	3,850	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	4.488400	0	0	88.00
90.00	09000	CLINIC	6.315787	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	27.057551	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.650821	0	0	90.02
90.03	09003	RHEUMATOLOGY	2.436219	0	0	90.03
90.04	09004	SPECIALTY CLINIC	2.317902	0	0	90.04
90.05	09005	PEDIATRICS	2.199357	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.526003	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.622056	6,051	3,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980505	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		64,199	14,902	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)		64,199		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/27/2021 7:43 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,855,841	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)	8,855,841	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)	8,944,399	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)	61,445	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,753,508	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)	4,129,446	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)	4,129,446	30.00
31.00	Primary payer payments	3,590	31.00
32.00	Subtotal (line 30 minus line 31)	4,125,856	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)	1,094,095	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	711,162	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	893,323	36.00
37.00	Subtotal (see instructions)	4,837,018	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)	4,837,018	40.00
40.01	Sequestration adjustment (see instructions)	31,924	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,654,991	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)	-849,897	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Prepared: 7/27/2021 7:43 am
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,233,235		5,654,991	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,233,235		5,654,991	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		220,374		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		849,897	6.02
7.00	Total Medicare program liability (see instructions)		1,453,609		4,805,094	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: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		173,956		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		173,956		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		13,227		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		187,183		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: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/27/2021 7:43 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	150,890	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)	37,537	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	87	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)	188,427	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	188,427	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)	188,427	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	188,427	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)	188,427	0	19.00
19.01	Sequestration adjustment (see instructions)	1,244	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	173,956	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)	13,227	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part V Date/Time Prepared: 7/27/2021 7:43 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,671,581	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)	1,671,581	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,688,297	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)	1,688,297	19.00
20.00	Deductibles (exclude professional component)	243,452	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,444,845	22.00
23.00	Coinsurance	1,760	23.00
24.00	Subtotal (line 22 minus line 23)	1,443,085	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,049	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,182	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,344	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,463,267	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)	1,463,267	30.00
30.01	Sequestration adjustment (see instructions)	9,658	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,233,235	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)	220,374	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	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII Date/Time Prepared: 7/27/2021 7:43 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	71,599		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	71,599	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	71,599	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	27,902		8.00
9.00	Ancillary service charges	64,199	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	92,101	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	92,101	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	20,502	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	71,599	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	71,599	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	71,599	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	71,599	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	71,599	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	71,599	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	71,599	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/27/2021 7:43 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,974,696	0	0	0	1.00
2.00	Temporary investments	2,302,467	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,517,136	0	0	0	4.00
5.00	Other receivable	410,404	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,585,570	0	0	0	6.00
7.00	Inventory	1,291,380	0	0	0	7.00
8.00	Prepaid expenses	590,483	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)	24,500,996	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	42,198,314	0	0	0	15.00
16.00	Accumulated depreciation	-25,506,915	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	16,691,399	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,192,395	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,627,065	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,391,871	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,850,482	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,869,418	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,884,924	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,884,924	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,754,342	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,438,053				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)	15,438,053	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,192,395	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/27/2021 7:43 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,282,225		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,157,109				2.00
3.00	Total (sum of line 1 and line 2)		15,439,334		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,439,334		0		11.00
12.00	PRIOR PERIOD ADJ	1,281		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)		1,281		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,438,053		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	PRIOR PERIOD ADJ		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: 15-1304 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/27/2021 7:43 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,323,330		3,323,330	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,323,330		3,323,330	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)	3,323,330		3,323,330	17.00
18.00	Ancillary services	3,844,219	73,151,457	76,995,676	18.00
19.00	Outpatient services	77,370	8,005,420	8,082,790	19.00
20.00	RURAL HEALTH CLINIC	3,454	830,349	833,803	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	749,288	749,288	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	378,488	8,839,202	9,217,690	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,626,861	91,575,716	99,202,577	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,339,861		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)		44,339,861		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1304	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 7/27/2021 7:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	99,202,577	1.00
2.00	Less contractual allowances and discounts on patients' accounts	57,390,682	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,811,895	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,339,861	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,527,966	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	OTHER OPERATING EXPENSES/INCOME	543,871	24.00
24.01	NON-OPERATING EXPENSES/INCOME	833,149	24.01
24.02	CONTRACT PHARMACY	807,289	24.02
24.50	COVID-19 PHE Funding	1,500,766	24.50
25.00	Total other income (sum of lines 6-24)	3,685,075	25.00
26.00	Total (line 5 plus line 25)	1,157,109	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)	1,157,109	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/27/2021 7:43 am

RHC I — Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	446,853	0	446,853	680,494	1,127,347	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	489,753	0	489,753	-108,037	381,716	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	35,498	0	35,498	0	35,498	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	45,779	0	45,779	0	45,779	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,017,883	0	1,017,883	572,457	1,590,340	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	8,919	8,919	-220	8,699	15.00
16.00	Transportation (Health Care Staff)	0	439	439	0	439	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	197,950	0	197,950	0	197,950	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	197,950	9,358	207,308	-220	207,088	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,215,833	9,358	1,225,191	572,237	1,797,428	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	14,613	14,613	0	14,613	29.00
30.00	Administrative Costs	301,774	47,351	349,125	2	349,127	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	301,774	61,964	363,738	2	363,740	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,517,607	71,322	1,588,929	572,239	2,161,168	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/27/2021 7:43 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,127,347	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	381,716	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	35,498	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	45,779	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,590,340	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	8,699	15.00
16.00	Transportation (Health Care Staff)	0	439	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	197,950	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	207,088	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,797,428	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	14,613	29.00
30.00	Administrative Costs	0	349,127	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	363,740	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,161,168	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2020 To 12/31/2020	Worksheet M-2 Date/Time Prepared: 7/27/2021 7:43 am
		RHC I	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.10	3,859	1	4		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	3.32	6,438	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.42	10,297		7	10,297	4.00
5.00	Visiting Nurse	0.82	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.73	8			8	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.97	10,305			10,305	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,797,428	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,797,428	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	363,740	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,581,273	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,945,013	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,945,013	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,945,013	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,742,441	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/27/2021 7:43 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,742,441	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		22,825	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,719,616	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,305	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,305	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		360.95	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	360.95	360.95	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,930	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	696,634	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	7	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	2,527	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	2,527	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	699,161	16.00
16.01	Total program charges (see instructions)(from contractor's records)		247,666	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		19,987	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		56,423	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		496,909	16.04
16.05	Total program cost (see instructions)	0	553,332	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,602	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,804	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		553,332	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		553,332	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		553,332	26.00
26.01	Sequestration adjustment (see instructions)		3,652	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		208,626	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		341,054	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/27/2021 7:43 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,590,340	1,590,340	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000408	0.001236	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	649	1,966	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,660	1,688	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,309	3,654	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,797,428	1,797,428	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,945,013	1,945,013	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004066	0.002033	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,908	3,954	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	15,217	7,608	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	7	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	1,086.86	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		22,825	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/27/2021 7:43 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		208,626	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		208,626	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		341,054	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		549,680	7.00

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