

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: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/27/2020 12:49 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2020	Time: 12:49 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ 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 IROQUOIS MEMORIAL HOSPITAL (14-0167) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DON WILLIAMS

Officer or Administrator of Provider(s)

CEO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	21,886	7,145	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RHC - GILMAN CLINIC I	0		-10,212		0	10.00
10.01	RHC II - MILFORD CLINIC	0		19,738		0	10.01
10.02	RHC III - KENTLAND CLINIC	0		51,215		0	10.02
10.03	RHC IV - MPS CLINIC	0		-13,295		0	10.03
200.00	Total	0	21,886	54,591	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:49 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 200 FAIRMAN AVENUE			PO Box:				1.00		
2.00	City: WATSEKA			State: IL		Zip Code: 60970		County:		
		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		IROQUOIS MEMORIAL HOSPITAL	140167	99914	1	07/01/1996	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		IROQUOIS MEMORIAL HOSPITAL	14U167	99914		12/31/2006	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		IROQUOIS RESIDENT HOME	146049	99914		08/18/2003	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		IROQUOIS HOME HEALTH	147586	99914		09/30/1994	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		IROQUOIS MEMORIAL HOSPICE	141616	99914		11/04/2004			
15.00	Hospital-Based Health Clinic - RHC		GILMAN CLINIC	143424	99914		09/04/1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		MILFORD CLINIC	143425	99914		10/09/1996	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		KENTLAND CLINIC	153979	99915		10/29/1996	N	O	N
15.03	Hospital-Based Health Clinic - RHC IV		MPS CLINIC	148551	99914		02/05/2016	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018		09/30/2019	
21.00	Type of Control (see instructions)						2			
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			
22.02	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			
22.03	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	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
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.	6	0	0	0	103	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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.					1		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.					10/01/2018	09/30/2019	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)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
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.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

		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 §413.85? (see instructions)	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	4.00
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
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)				0.00
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)				
61.03	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)				
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				
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)				
61.06	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)				
		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
61.20	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
					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
62.01	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
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
		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

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Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	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	
70.00	Inpatient Psychiatric Facility PPS					
	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
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:49 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:49 pm	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
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:	486,341	0	0	
		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.	Y			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.	Y	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
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	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 12:49 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	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.				N			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.							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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	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		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 12:49 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			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	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	01/28/2020	Y	01/28/2020
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	SHAWN	ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(502) 992-3508	SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0167

Period:
From 10/01/2018
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Date/Time Prepared:
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		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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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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	9,125	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	0.00	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	9,125	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	35	12,775		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC - GILMAN CLINIC	88.00				0	26.00
26.01 RHC II - MILFORD CLINIC	88.01				0	26.01
26.02 RHC III - KENTLAND CLINIC	88.02				0	26.02
26.03 RHC IV - MPS CLINIC	88.03				0	26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		61				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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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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)	698	6	1,005			1.00
2.00	HMO and other (see instructions)	102	103				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	698	6	1,005			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)	698	6	1,005	0.00	231.62	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	1,569	0	10,177	0.00	28.01	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,637	0	3,779	0.00	11.71	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	2	0	10	0.00	15.04	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - GILMAN CLINIC	1,658	0	4,885	0.00	5.94	26.00
26.01	RHC II - MILFORD CLINIC	921	0	2,291	0.00	4.57	26.01
26.02	RHC III - KENTLAND CLINIC	3,069	0	6,409	0.00	8.21	26.02
26.03	RHC IV - MPS CLINIC	1,928	0	6,579	0.00	5.78	26.03
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	310.88	27.00
28.00	Observation Bed Days		7	624			28.00
29.00	Ambulance Trips	264					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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	256	2	402	1.00
2.00 HMO and other (see instructions)			0	41		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	256	2	402	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	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC - GILMAN CLINIC	0.00					26.00
26.01 RHC II - MILFORD CLINIC	0.00					26.01
26.02 RHC III - KENTLAND CLINIC	0.00					26.02
26.03 RHC IV - MPS CLINIC	0.00					26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	14,533,056	0	14,533,056	646,638.36	22.47
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		323	0	323	1.95	165.64
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		299,767	0	299,767	1,140.00	262.95
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,282,486	0	2,282,486	50,966.00	44.78
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,391,885	0	1,391,885	58,265.91	23.89
10.00	Excluded area salaries (see instructions)		1,546,718	0	1,546,718	88,589.44	17.46
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		323,429	0	323,429	4,167.12	77.61
12.00	Contract labor: Top level management and other management and administrative services		315,498	0	315,498	1,213.33	260.03
13.00	Contract labor: Physician-Part A - Administrative		16,075	0	16,075	108.80	147.75
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,805,227	0	1,805,227		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		590,929	0	590,929		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		24,251	0	24,251		
24.00	Wage-related costs (RHC/FQHC)		294,592	0	294,592		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	195,980	0	195,980	5,922.25	33.09
27.00	Administrative & General	5.00	1,671,907	0	1,671,907	85,544.62	19.54

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	281,388	0	281,388	17,516.17	16.06	30.00
31.00	Laundry & Linen Service	8.00	40,891	0	40,891	3,754.25	10.89	31.00
32.00	Housekeeping	9.00	286,454	0	286,454	26,674.91	10.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	347,075	-135,394	211,681	15,974.85	13.25	34.00
35.00	Dietary under contract (see instructions)		13,080	0	13,080	216.75	60.35	35.00
36.00	Cafeteria	11.00	0	135,394	135,394	11,561.76	11.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	167,849	0	167,849	2,025.75	82.86	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	253,548	0	253,548	14,292.50	17.74	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/27/2020 12:49 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	11,963,883	0	11,963,883	594,749.11	20.12	1.00
2.00	Excluded area salaries (see instructions)	2,938,603	0	2,938,603	146,855.35	20.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,025,280	0	9,025,280	447,893.76	20.15	3.00
4.00	Subtotal other wages & related costs (see inst.)	655,002	0	655,002	5,489.25	119.32	4.00
5.00	Subtotal wage-related costs (see inst.)	1,805,227	0	1,805,227	0.00	20.00	5.00
6.00	Total (sum of lines 3 thru 5)	11,485,509	0	11,485,509	453,383.01	25.33	6.00
7.00	Total overhead cost (see instructions)	3,258,172	0	3,258,172	183,483.81	17.76	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2020 12:49 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		1,679,056	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		5,925	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		975,328	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		54,690	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,714,999	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0167

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet S-3
 Part V
 Date/Time Prepared:
 2/27/2020 12:49 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	323,429	2,714,999	1.00
2.00	Hospital	323,429	2,714,999	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-7586		Period: From 10/01/2018 To 09/30/2019		Worksheet S-4 Date/Time Prepared: 2/27/2020 12:49 pm	
				Home Health Agency I		PPS	
				1.00			
0.00 County				IROQUOIS		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,281	0	99	2,380	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	177.00	4.00	40.00	221.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.26	0.00	0.26	3.00
4.00	Director(s) and Assistant Director(s)			0.12	0.00	0.12	4.00
5.00	Other Administrative Personnel			0.09	0.00	0.09	5.00
6.00	Direct Nursing Service			2.83	0.00	2.83	6.00
7.00	Nursing Supervisor			0.55	0.00	0.55	7.00
8.00	Physical Therapy Service			1.32	0.00	1.32	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.20	0.00	0.20	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.14	0.00	1.14	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	16580					20.00
20.01		19180					20.01
20.02		99914					20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,148	176	30	11	1,365	21.00
22.00	Skilled Nursing Visit Charges	185,425	28,428	4,846	1,777	220,476	22.00
23.00	Physical Therapy Visits	733	18	9	3	763	23.00
24.00	Physical Therapy Visit Charges	118,394	2,907	1,454	485	123,240	24.00
25.00	Occupational Therapy Visits	125	7	1	0	133	25.00
26.00	Occupational Therapy Visit Charges	20,190	1,131	162	0	21,483	26.00
27.00	Speech Pathology Visits	10	4	0	0	14	27.00
28.00	Speech Pathology Visit Charges	1,615	646	0	0	2,261	28.00
29.00	Medical Social Service Visits	7	0	1	0	8	29.00
30.00	Medical Social Service Visit Charges	1,404	0	201	0	1,605	30.00
31.00	Home Health Aide Visits	298	53	2	1	354	31.00
32.00	Home Health Aide Visit Charges	29,877	5,314	201	100	35,492	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,321	258	43	15	2,637	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	356,905	38,426	6,864	2,362	404,557	35.00
36.00	Total Number of Episodes (standard/non outlier)	146		13	2	161	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	8,245	2,191	20	31	10,487	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 12:49 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	17	0	17 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	126	0	126 12.00
13.00		RUB	28	0	28 13.00
14.00		RUA	81	0	81 14.00
15.00		RVC	385	0	385 15.00
16.00		RVB	135	0	135 16.00
17.00		RVA	278	0	278 17.00
18.00		RHC	52	0	52 18.00
19.00		RHB	34	0	34 19.00
20.00		RHA	76	0	76 20.00
21.00		RMC	21	0	21 21.00
22.00		RMB	78	0	78 22.00
23.00		RMA	25	0	25 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	6	0	6 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	3	0	3 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	14	0	14 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	6	0	6 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	76	0	76 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	28	0	28 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	7	0	7 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	32	0	32 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 12:49 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	30	0	30	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	8	0	8	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	23	0	23	199.00
200.00	TOTAL		1,569	0	1,569	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,716,921			207.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-3424		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 12:49 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	508 E CRESENT			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GILMAN IL 60938			2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0			3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N 0			10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		5.00			
Facility hours of operations (1)					
11.00	CLINIC	08:30		18:30	07:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			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
		1.00	2.00	3.00	4.00
		Total Visits			5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County	IROQUOIS			2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	07:00	17:00	08:30
		18:30			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-3424

From 10/01/2018

To 09/30/2019

Date/Time Prepared:
2/27/2020 12:49 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:30	17:00				11.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-3425		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 12:49 pm	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	207 N AXTEL		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MILFORD IL 60983		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0		3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		08:30		17:00	
		07:00		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		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
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00		11.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:30	18:30	08:30
		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-3425

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

RHC II

Cost

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 15-3979		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 12:49 pm	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	303 N SEVENTH		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KENTLAND IN		47951	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:00		17:00	08:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	NEWTON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	18:30	07:00	17:00	08:30
		18:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 15-3979

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

RHC III

Cost

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-8551		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 12:49 pm		
		RHC IV		Cost		
		1.00				
1.00	Clinic Address and Identification	200 FAIRMAN AVE				1.00
	Street					
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	WATSEKA		IL 60970		2.00
		1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
		Grant Award		Date		
		1.00		2.00		
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00				2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N				0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			07:00	17:00	08:30
		1.00				2.00
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N				0 13.00
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	IROQUOIS				2.00
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	CLINIC	18:30	07:00	17:00	08:30	18:30

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-8551

From 10/01/2018

To 09/30/2019

Date/Time Prepared:
2/27/2020 12:49 pm

RHC IV

Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

 Provider CCN: 14-0167
 Hospice CCN: 14-1616

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet S-9
 PARTS I THROUGH IV
 Date/Time Prepared:
 2/27/2020 12:49 pm

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	1	0	1	10.00
11.00	Hospice Routine Home Care	5,899	199	132	6,230	11.00
12.00	Hospice Inpatient Respite Care	20	0	0	20	12.00
13.00	Hospice General Inpatient Care	30	0	3	33	13.00
14.00	Total Hospice Days	5,949	200	135	6,284	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-10

Date/Time Prepared:
2/27/2020 12:49 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.467408	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,901,579	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		645,418	5.00
6.00	Medicaid charges		12,932,757	6.00
7.00	Medicaid cost (line 1 times line 6)		6,044,874	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)		3,497,877	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)		3,497,877	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	271,162	232,611	503,773
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	126,743	232,611	359,354
22.00	Payments received from patients for amounts previously written off as charity care	0	444	444
23.00	Cost of charity care (line 21 minus line 22)	126,743	232,167	358,910
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,170,417	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		33,907	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		52,164	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,118,253	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,008,345	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,367,255	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,865,132	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	934,317	934,317	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	676,576	676,576	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	195,980	256,476	452,456	1,700,673	2,153,129	4.00
5.01	00570	ADMITTING	259,250	28,728	287,978	-1,587	286,391	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	52,977	19,670	72,647	-291	72,356	5.02
5.03	00550	DATA PROCESSING	276,357	658,907	935,264	2,769	938,033	5.03
5.04	01160	COMMUNICATIONS	0	103,493	103,493	6,565	110,058	5.04
5.05	00590	BUSINESS OFFICE	434,328	31,121	465,449	-1,772	463,677	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	648,995	4,580,022	5,229,017	-1,457,394	3,771,623	5.06
7.00	00700	OPERATION OF PLANT	281,388	703,370	984,758	-2,386	982,372	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,891	2,322	43,213	0	43,213	8.00
9.00	00900	HOUSEKEEPING	286,454	33,039	319,493	0	319,493	9.00
10.00	01000	DIETARY	347,075	319,977	667,052	-260,651	406,401	10.00
11.00	01100	CAFETERIA	0	0	0	259,940	259,940	11.00
13.00	01300	NURSING ADMINISTRATION	167,849	33,583	201,432	0	201,432	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,965	10,965	0	10,965	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	253,548	15,357	268,905	-9	268,896	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,194,599	2,144,821	3,339,420	-1,437,376	1,902,044	30.00
44.00	04400	SKILLED NURSING FACILITY	1,391,885	178,993	1,570,878	-45	1,570,833	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	525,176	535,028	1,060,204	-158,802	901,402	50.00
53.00	05300	ANESTHESIOLOGY	0	634,412	634,412	-939	633,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	451,386	683,676	1,135,062	-115,379	1,019,683	54.00
57.00	05700	CT SCAN	184,107	16,745	200,852	0	200,852	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,657	199,228	283,885	0	283,885	58.00
60.00	06000	LABORATORY	618,406	1,005,030	1,623,436	-30,013	1,593,423	60.00
65.00	06500	RESPIRATORY THERAPY	490,495	87,629	578,124	-44,151	533,973	65.00
66.00	06600	PHYSICAL THERAPY	692,963	49,384	742,347	-7,232	735,115	66.00
69.00	06900	ELECTROCARDIOLOGY	32,852	-32,678	174	-5	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	124,293	124,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	429,179	429,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	436,111	1,200,650	1,636,761	-14,353	1,622,408	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	460,909	84,742	545,651	-6,926	538,725	88.00
88.01	08801	RHC II - MILFORD CLINIC	256,026	160,676	416,702	-68,725	347,977	88.01
88.02	08802	RHC III - KENTLAND CLINIC	698,339	248,228	946,567	-73,857	872,710	88.02
88.03	08803	RHC IV - MPS CLINIC	1,012,565	241,762	1,254,327	-250,167	1,004,160	88.03
90.00	09000	CLINIC	210,819	204,010	414,829	-14,588	400,241	90.00
91.00	09100	EMERGENCY	999,951	2,640,775	3,640,726	-11,339	3,629,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	294,838	5,178	300,016	-6,252	293,764	95.00
101.00	10100	HOME HEALTH AGENCY	464,302	78,834	543,136	-12,322	530,814	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		198,623	198,623	-155,289	43,334	113.00
116.00	11600	HOSPICE	600,797	269,749	870,546	-2,462	868,084	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,346,275	17,632,525	31,978,800	0	31,978,800	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	541	541	0	541	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	3,524	3,524	0	3,524	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	40,545	53,047	93,592	0	93,592	194.01
194.02	07952	REFERENCE LAB	146,236	868,007	1,014,243	0	1,014,243	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	14,533,056	18,557,644	33,090,700	0	33,090,700	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	934,317	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	676,576	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-684	2,152,445	4.00
5.01	00570	ADMITTING	0	286,391	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-14	72,342	5.02
5.03	00550	DATA PROCESSING	-58,756	879,277	5.03
5.04	01160	COMMUNICATIONS	-11,349	98,709	5.04
5.05	00590	BUSINESS OFFICE	0	463,677	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	-1,268,325	2,503,298	5.06
7.00	00700	OPERATION OF PLANT	-6,617	975,755	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,213	8.00
9.00	00900	HOUSEKEEPING	-1,933	317,560	9.00
10.00	01000	DIETARY	-17,520	388,881	10.00
11.00	01100	CAFETERIA	-132,948	126,992	11.00
13.00	01300	NURSING ADMINISTRATION	0	201,432	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-772	10,193	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,328	247,568	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-145,582	1,756,462	30.00
44.00	04400	SKILLED NURSING FACILITY	-3,409	1,567,424	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-172,884	728,518	50.00
53.00	05300	ANESTHESIOLOGY	-625,278	8,195	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,161	991,522	54.00
57.00	05700	CT SCAN	-810	200,042	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	283,885	58.00
60.00	06000	LABORATORY	-200,183	1,393,240	60.00
65.00	06500	RESPIRATORY THERAPY	-7,909	526,064	65.00
66.00	06600	PHYSICAL THERAPY	-5,400	729,715	66.00
69.00	06900	ELECTROCARDIOLOGY	0	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	124,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	429,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,622,408	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - GILMAN CLINIC	0	538,725	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	347,977	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	872,710	88.02
88.03	08803	RHC IV - MPS CLINIC	0	1,004,160	88.03
90.00	09000	CLINIC	-155,281	244,960	90.00
91.00	09100	EMERGENCY	-2,400,519	1,228,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-11,074	282,690	95.00
101.00	10100	HOME HEALTH AGENCY	0	530,814	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-43,334	0	113.00
116.00	11600	HOSPICE	-52	868,032	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,320,122	26,658,678	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	541	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	3,524	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	93,592	194.01
194.02	07952	REFERENCE LAB	0	1,014,243	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,320,122	27,770,578	200.00

RECLASSIFICATIONS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 12:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES					
1.00	PURCHASING RECEIVING AND STORES	5.02	0	16		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	124,293		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	429,179		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
	TOTALS		0	553,488		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	31,802		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
	TOTALS		0	31,802		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	844,250		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	611,354		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
	TOTALS		0	1,455,604		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,067		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	65,222		2.00
	TOTALS		0	155,289		
	E - TELEPHONE					
1.00	COMMUNICATIONS	5.04	0	6,565		1.00
2.00	DATA PROCESSING	5.03	0	2,769		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,647		3.00
4.00	LABORATORY	60.00	0	3,186		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,626		5.00
6.00	EMERGENCY	91.00	0	2,647		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	21,440		
	F - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,723,306		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
	TOTALS		0	1,723,306		
	G - CAFETERIA					
1.00	CAFETERIA	11.00	135,394	124,546		1.00
	TOTALS		135,394	124,546		
	H - RHC SALARIES					
1.00	OPERATING ROOM	50.00	151,037	0		1.00
2.00	RHC - GILMAN CLINIC	88.00	514	0		2.00
3.00	RHC II - MILFORD CLINIC	88.01	313	0		3.00

RECLASSIFICATIONS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 12:49 pm

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00	RHC III - KENTLAND CLINIC	88.02	257	0		4.00
5.00	CLINIC	90.00	10,537	0		5.00
	TOTALS		162,658	0		
500.00	Grand Total: Increases		298,052	4,065,475		500.00

RECLASSIFICATIONS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 12:49 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	8,196	0		1.00
2.00	OPERATING ROOM	50.00	0	308,503	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	939	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	109,107	0		4.00
5.00	LABORATORY	60.00	0	20,117	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	44,151	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	7	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	5	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	49,781	0		9.00
10.00	CLINIC	90.00	0	1,136	0		10.00
11.00	EMERGENCY	91.00	0	11,546	0		11.00
	TOTALS		0	553,488			
	B - DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22,326	0		1.00
2.00	DIETARY	10.00	0	711	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	9	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	73	0		4.00
5.00	OPERATING ROOM	50.00	0	1,336	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,185	0		6.00
7.00	LABORATORY	60.00	0	540	0		7.00
8.00	CLINIC	90.00	0	970	0		8.00
9.00	EMERGENCY	91.00	0	1,652	0		9.00
	TOTALS		0	31,802			
	C - DEPRECIATION						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,412,014	9		1.00
2.00	RHC - GILMAN CLINIC	88.00	0	105	9		2.00
3.00	RHC II - MILFORD CLINIC	88.01	0	17,182	0		3.00
4.00	RHC III - KENTLAND CLINIC	88.02	0	8,589	0		4.00
5.00	RHC IV - MPS CLINIC	88.03	0	13,341	0		5.00
6.00	CLINIC	90.00	0	4,373	0		6.00
	TOTALS		0	1,455,604			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	155,289	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	155,289			
	E - TELEPHONE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	307	0		1.00
2.00	ADMITTING	5.01	0	1,587	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	307	0		3.00
4.00	BUSINESS OFFICE	5.05	0	1,772	0		4.00
5.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	4,979	0		5.00
6.00	OPERATION OF PLANT	7.00	0	2,317	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	6,729	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	3,442	0		8.00
	TOTALS		0	21,440			
	F - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	40,401	0		1.00
2.00	OPERATION OF PLANT	7.00	0	69	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,412,886	0		3.00
4.00	SKILLED NURSING FACILITY	44.00	0	45	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,734	0		5.00
6.00	LABORATORY	60.00	0	12,542	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	496	0		7.00
8.00	RHC - GILMAN CLINIC	88.00	0	7,335	0		8.00
9.00	RHC II - MILFORD CLINIC	88.01	0	51,856	0		9.00
10.00	RHC III - KENTLAND CLINIC	88.02	0	65,525	0		10.00
11.00	RHC IV - MPS CLINIC	88.03	0	90,389	0		11.00
12.00	CLINIC	90.00	0	18,646	0		12.00
13.00	EMERGENCY	91.00	0	788	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	2,810	0		14.00
15.00	HOME HEALTH AGENCY	101.00	0	12,322	0		15.00
16.00	HOSPICE	116.00	0	2,462	0		16.00
	TOTALS		0	1,723,306			
	G - CAFETERIA						
1.00	DIETARY	10.00	135,394	124,546	0		1.00
	TOTALS		135,394	124,546			

RECLASSIFICATIONS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 12:49 pm

	Decreases						2/27/2025 12:45 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - RHC SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	16,221	0	0		1.00
2.00	RHC IV - MPS CLINIC	88.03	146,437	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
	TOTALS		162,658	0			
500.00	Grand Total: Decreases		298,052	4,065,475			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	319,450	18,500	0	18,500	0	1.00	
2.00	Land Improvements	0	483,553	0	483,553	0	2.00	
3.00	Buildings and Fixtures	25,940,678	0	0	0	26,338	3.00	
4.00	Building Improvements	483,750	0	0	0	483,750	4.00	
5.00	Fixed Equipment	0	16,002,690	0	16,002,690	0	5.00	
6.00	Movable Equipment	16,795,318	0	0	0	16,795,318	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	43,539,196	16,504,743	0	16,504,743	17,305,406	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	43,539,196	16,504,743	0	16,504,743	17,305,406	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	337,950	0				1.00	
2.00	Land Improvements	483,553	0				2.00	
3.00	Buildings and Fixtures	25,914,340	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	16,002,690	0				5.00	
6.00	Movable Equipment	0	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	42,738,533	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	42,738,533	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	42,738,533	0	42,738,533	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	42,738,533	0	42,738,533	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	844,250	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	611,354	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,455,604	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	90,067	0	0	0	934,317	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,222	0	0	0	676,576	2.00
3.00	Total (sum of lines 1-2)	155,289	0	0	0	1,610,893	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-43,334	INTEREST EXPENSE	113.00	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)	A	-8,954	COMMUNICATIONS	5.04	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	-3,587,748			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	-210,000			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-132,948	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	LOBBYING DUES	A	-7,596	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.00
33.01	LOBBYING DUES	A	-52	HOSPICE	116.00	0	33.01
34.00	MISCELLANEOUS NON-PATIENT REVENUE	B	-684	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	MISCELLANEOUS NON-PATIENT REVENUE	B	-14	PURCHASING RECEIVING AND STORES	5.02	0	34.01
34.02	MISCELLANEOUS NON-PATIENT REVENUE	B	-58,756	DATA PROCESSING	5.03	0	34.02
34.03	MISCELLANEOUS NON-PATIENT REVENUE	B	-1,391	OTHER ADMINISTRATIVE & GENERAL	5.06	0	34.03
34.04	MISCELLANEOUS NON-PATIENT REVENUE	B	-1,933	HOUSEKEEPING	9.00	0	34.04
34.05	MISCELLANEOUS NON-PATIENT REVENUE	B	-19,765	DIETARY	10.00	0	34.05
34.06	MISCELLANEOUS NON-PATIENT REVENUE	B	-772	CENTRAL SERVICES & SUPPLY	14.00	0	34.06
34.07	MISCELLANEOUS NON-PATIENT REVENUE	B	-21,328	MEDICAL RECORDS & LIBRARY	16.00	0	34.07
34.08	MISCELLANEOUS NON-PATIENT REVENUE	B	-3,409	SKILLED NURSING FACILITY	44.00	0	34.08
34.09	MISCELLANEOUS NON-PATIENT REVENUE	B	-1,215	RADIOLOGY-DIAGNOSTIC	54.00	0	34.09
34.10	MISCELLANEOUS NON-PATIENT REVENUE	B	-139	RESPIRATORY THERAPY	65.00	0	34.10
34.11	MISCELLANEOUS NON-PATIENT REVENUE	B	-15	CLINIC	90.00	0	34.11
35.00	RENTAL INCOME	B	-31,841	OTHER ADMINISTRATIVE & GENERAL	5.06	0	35.00
35.01	RENTAL INCOME	B	-5,400	PHYSICAL THERAPY	66.00	0	35.01
35.02	RENTAL INCOME	B	-143,469	CLINIC	90.00	0	35.02
36.00	COGS - PURCHASING	B	1,776	OPERATION OF PLANT	7.00	0	36.00
36.01	COGS - PURCHASING	B	2,245	DIETARY	10.00	0	36.01
36.02	COGS - PURCHASING	B	-4,021	OPERATING ROOM	50.00	0	36.02
37.00	AMBULANCE SUBSIDY	B	-11,074	AMBULANCE SERVICES	95.00	0	37.00
38.00	NONALLOWABLE EXPENSES	A	-141,767	OTHER ADMINISTRATIVE & GENERAL	5.06	0	38.00
39.00	PROVIDER TAX	A	-875,730	OTHER ADMINISTRATIVE & GENERAL	5.06	0	39.00
40.00	PATIENT TELEVISION	A	-8,393	OPERATION OF PLANT	7.00	0	40.00
41.00	PATIENT TELEVISION	A	-2,395	COMMUNICATIONS	5.04	0	41.00
41.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,320,122				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 12:49 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	35,000	245,000	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			35,000	245,000	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	F	DON WILLIAMS	0.00	GEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 12:49 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-210,000	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-210,000			5.00

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

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

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

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

6.00	MANAGMENT SVCS		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 12:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	145,582	145,582	0	211,500	0	1.00
2.00	50.00	OPERATING ROOM	169,100	168,738	362	246,400	2	2.00
3.00	53.00	ANESTHESIOLOGY	625,278	625,278	0	239,400	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	40,541	24,941	15,600	271,900	104	4.00
5.00	57.00	CT SCAN	810	810	0	271,900	0	5.00
6.00	60.00	LABORATORY	200,183	200,183	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	7,770	7,770	0	211,500	0	7.00
8.00	90.00	CLINIC	11,797	11,797	0	211,500	0	8.00
9.00	91.00	EMERGENCY	2,400,994	2,400,519	475	211,500	5	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,602,055	3,585,618	16,437		111	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	237	12	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	13,595	680	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	508	25	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			14,340	717	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	145,582		1.00
2.00	50.00	OPERATING ROOM	0	237	125	168,863		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	625,278		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	13,595	2,005	26,946		4.00
5.00	57.00	CT SCAN	0	0	0	810		5.00
6.00	60.00	LABORATORY	0	0	0	200,183		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	7,770		7.00
8.00	90.00	CLINIC	0	0	0	11,797		8.00
9.00	91.00	EMERGENCY	0	508	0	2,400,519		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	14,340	2,130	3,587,748		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	934,317	934,317			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	676,576		676,576		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,152,445	12,118	1,504	2,166,067	4.00
5.01	00570	ADMITTING	286,391	3,915	1,275	39,168	330,749 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	72,342	6,547	855	8,004	0 5.02
5.03	00550	DATA PROCESSING	879,277	9,499	41,123	41,753	0 5.03
5.04	01160	COMMUNICATIONS	98,709	6,337	0	0	0 5.04
5.05	00590	BUSINESS OFFICE	463,677	9,173	374	65,619	0 5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	2,503,298	76,689	5,660	98,051	0 5.06
7.00	00700	OPERATION OF PLANT	975,755	87,924	78,388	42,513	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,213	15,564	81	6,178	0 8.00
9.00	00900	HOUSEKEEPING	317,560	4,539	90	43,278	0 9.00
10.00	01000	DIETARY	388,881	23,299	1,512	31,981	0 10.00
11.00	01100	CAFETERIA	126,992	7,056	0	20,456	0 11.00
13.00	01300	NURSING ADMINISTRATION	201,432	5,950	0	25,359	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,193	10,211	4,456	0	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	247,568	11,161	54	38,307	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,756,462	58,431	37,235	178,032	15,183 30.00
44.00	04400	SKILLED NURSING FACILITY	1,567,424	65,236	18,136	210,279	15,949 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	728,518	110,541	158,226	102,164	24,113 50.00
53.00	05300	ANESTHESIOLOGY	8,195	2,266	530	0	632 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	991,522	32,024	61,671	68,196	38,398 54.00
57.00	05700	CT SCAN	200,042	5,251	83,879	27,815	42,087 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	283,885	0	266	12,790	7,977 58.00
60.00	06000	LABORATORY	1,393,240	23,889	16,263	93,430	54,104 60.00
65.00	06500	RESPIRATORY THERAPY	526,064	17,023	11,802	74,105	4,574 65.00
66.00	06600	PHYSICAL THERAPY	729,715	83,881	22,595	104,694	15,865 66.00
69.00	06900	ELECTROCARDIOLOGY	169	1,520	4,840	4,963	3,256 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	124,293	0	0	0	3,549 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	429,179	0	0	0	5,443 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,622,408	12,701	3,774	65,889	26,760 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	538,725	17,641	408	69,713	3,389 88.00
88.01	08801	RHC II - MILFORD CLINIC	347,977	18,726	14,174	38,728	1,721 88.01
88.02	08802	RHC III - KENTLAND CLINIC	872,710	28,578	7,391	105,545	5,293 88.02
88.03	08803	RHC IV - MPS CLINIC	1,004,160	19,968	11,844	130,856	4,386 88.03
90.00	09000	CLINIC	244,960	45,411	2,786	33,443	1,284 90.00
91.00	09100	EMERGENCY	1,228,868	20,117	23,228	151,075	41,668 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	282,690	1,404	28,903	44,545	6,001 95.00
101.00	10100	HOME HEALTH AGENCY	530,814	24,615	13,467	70,148	3,488 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	868,032	24,615	13,715	90,770	5,629 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,658,678	903,820	670,505	2,137,847	330,749 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	541	6,228	0	0	0 190.00
194.00	07950	IROQUOIS WOMENS HEALTH	3,524	11,181	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	93,592	13,088	3,904	6,126	0 194.01
194.02	07952	REFERENCE LAB	1,014,243	0	2,167	22,094	0 194.02
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	27,770,578	934,317	676,576	2,166,067	330,749 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	87,748					5.02
5.03	00550	DATA PROCESSING	510	972,162				5.03
5.04	01160	COMMUNICATIONS	0	0	105,046			5.04
5.05	00590	BUSINESS OFFICE	105	27,388	3,045	569,381		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	1,140	30,093	6,394	0	2,721,325	5.06
7.00	00700	OPERATION OF PLANT	1,073	26,667	3,654	0	1,215,974	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94	3,909	304	0	69,343	8.00
9.00	00900	HOUSEKEEPING	1,573	42,045	304	0	409,389	9.00
10.00	01000	DIETARY	1,050	26,024	2,740	0	475,487	10.00
11.00	01100	CAFETERIA	759	21,532	0	0	176,795	11.00
13.00	01300	NURSING ADMINISTRATION	9	16,158	3,349	0	252,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	558	0	0	0	25,418	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76	28,291	10,657	0	336,114	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,902	87,474	21,010	26,135	2,181,864	30.00
44.00	04400	SKILLED NURSING FACILITY	887	97,954	3,654	27,454	2,006,973	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,181	40,025	11,266	41,506	1,224,540	50.00
53.00	05300	ANESTHESIOLOGY	223	0	0	1,087	12,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,654	41,498	6,699	66,095	1,308,757	54.00
57.00	05700	CT SCAN	0	6,191	0	72,445	437,710	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,090	0	13,732	322,740	58.00
60.00	06000	LABORATORY	26,153	47,449	4,872	93,186	1,752,586	60.00
65.00	06500	RESPIRATORY THERAPY	1,494	27,838	3,045	7,873	673,818	65.00
66.00	06600	PHYSICAL THERAPY	268	30,671	304	27,309	1,015,302	66.00
69.00	06900	ELECTROCARDIOLOGY	16	3,758	1,218	5,605	25,345	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,329	0	0	6,108	140,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,856	0	0	9,369	465,847	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,000	21,298	2,436	46,063	1,802,329	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	174	16,768	0	5,834	652,652	88.00
88.01	08801	RHC II - MILFORD CLINIC	133	14,047	0	2,962	438,468	88.01
88.02	08802	RHC III - KENTLAND CLINIC	1,911	24,930	0	9,111	1,055,469	88.02
88.03	08803	RHC IV - MPS CLINIC	235	27,811	7,612	7,549	1,214,421	88.03
90.00	09000	CLINIC	577	20,803	5,176	2,211	356,651	90.00
91.00	09100	EMERGENCY	2,360	53,390	5,785	71,725	1,598,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	257	78,392	0	10,329	452,521	95.00
101.00	10100	HOME HEALTH AGENCY	346	23,345	0	6,003	672,226	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,599	49,878	0	9,690	1,064,928	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,502	939,717	103,524	569,381	26,558,677	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12	0	609	0	7,390	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	9	8,299	0	0	23,013	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	141	23,876	609	0	141,336	194.01
194.02	07952	REFERENCE LAB	1,084	270	304	0	1,040,162	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	87,748	972,162	105,046	569,381	27,770,578	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
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Cost Center Description			OTHER ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	2,721,325					5.06
7.00	00700	OPERATION OF PLANT	132,102	1,348,076				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,533	29,056	105,932			8.00
9.00	00900	HOUSEKEEPING	44,476	8,474	0	462,339		9.00
10.00	01000	DIETARY	51,656	43,496	0	15,345	585,984	10.00
11.00	01100	CAFETERIA	19,207	13,173	0	4,647	0	11.00
13.00	01300	NURSING ADMINISTRATION	27,405	11,108	0	3,919	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,761	19,063	0	6,725	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,515	20,836	0	7,351	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	237,037	109,081	19,630	38,482	60,082	30.00
44.00	04400	SKILLED NURSING FACILITY	218,036	121,785	37,837	42,964	446,483	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133,033	206,357	6,541	72,799	589	50.00
53.00	05300	ANESTHESIOLOGY	1,405	4,231	0	1,492	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,182	59,784	8,393	21,091	0	54.00
57.00	05700	CT SCAN	47,552	9,804	0	3,459	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35,062	0	0	0	0	58.00
60.00	06000	LABORATORY	190,399	44,598	206	15,733	0	60.00
65.00	06500	RESPIRATORY THERAPY	73,203	31,779	0	11,211	0	65.00
66.00	06600	PHYSICAL THERAPY	110,301	156,592	8,031	55,243	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,753	2,837	0	1,001	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,240	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,609	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,803	23,711	0	8,365	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	70,903	32,932	0	11,618	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	47,635	34,959	0	12,333	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	114,665	53,350	0	18,821	0	88.02
88.03	08803	RHC IV - MPS CLINIC	131,933	37,277	0	13,151	0	88.03
90.00	09000	CLINIC	38,746	84,775	2,338	29,907	1,163	90.00
91.00	09100	EMERGENCY	173,629	37,555	21,096	13,249	7,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	49,161	2,622	1,860	925	0	95.00
101.00	10100	HOME HEALTH AGENCY	73,030	45,953	0	16,211	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	115,693	45,953	0	16,211	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,589,665	1,291,141	105,932	442,253	515,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	803	11,628	0	4,102	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	2,500	20,874	0	7,364	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	15,355	24,433	0	8,620	70,415	194.01
194.02	07952	REFERENCE LAB	113,002	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,721,325	1,348,076	105,932	462,339	585,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
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	213,822					11.00
13.00	01300	NURSING ADMINISTRATION	1,182	295,871				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	53,967			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,372	0	51	409,239		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,827	117,630	1,269	18,785	2,817,687	30.00
44.00	04400	SKILLED NURSING FACILITY	34,132	0	592	19,732	2,928,534	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,122	56,035	5,459	29,833	1,751,308	50.00
53.00	05300	ANESTHESIOLOGY	0	0	149	782	20,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,499	0	1,771	47,507	1,605,984	54.00
57.00	05700	CT SCAN	7,714	0	0	52,070	558,309	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,889	0	0	9,870	369,561	58.00
60.00	06000	LABORATORY	17,182	0	17,449	66,970	2,105,123	60.00
65.00	06500	RESPIRATORY THERAPY	8,859	30,812	997	5,658	836,337	65.00
66.00	06600	PHYSICAL THERAPY	18,035	0	179	19,629	1,383,312	66.00
69.00	06900	ELECTROCARDIOLOGY	670	0	11	4,029	36,646	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,224	4,390	164,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	14,584	6,734	537,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,493	0	668	33,108	2,072,477	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	0	116	4,193	772,414	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0	89	2,129	535,613	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0	1,275	6,549	1,250,129	88.02
88.03	08803	RHC IV - MPS CLINIC	7,043	0	157	5,426	1,409,408	88.03
90.00	09000	CLINIC	4,813	16,751	385	1,589	537,118	90.00
91.00	09100	EMERGENCY	21,471	74,643	1,575	51,553	2,000,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	171	7,424	514,684	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	231	4,315	811,966	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	1,734	6,964	1,251,483	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206,303	295,871	53,136	409,239	26,271,231	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	8	0	23,931	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	6	0	53,757	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	3,071	0	94	0	263,324	194.01
194.02	07952	REFERENCE LAB	4,448	0	723	0	1,158,335	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	213,822	295,871	53,967	409,239	27,770,578	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	DATA PROCESSING			5.03
5.04	01160	COMMUNICATIONS			5.04
5.05	00590	BUSINESS OFFICE			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL			5.06
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	0	2,817,687	30.00
44.00	04400	SKILLED NURSING FACILITY	0	2,928,534	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,751,308	50.00
53.00	05300	ANESTHESIOLOGY	0	20,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,605,984	54.00
57.00	05700	CT SCAN	0	558,309	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	369,561	58.00
60.00	06000	LABORATORY	0	2,105,123	60.00
65.00	06500	RESPIRATORY THERAPY	0	836,337	65.00
66.00	06600	PHYSICAL THERAPY	0	1,383,312	66.00
69.00	06900	ELECTROCARDIOLOGY	0	36,646	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	164,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	537,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,072,477	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - GILMAN CLINIC	0	772,414	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	535,613	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	1,250,129	88.02
88.03	08803	RHC IV - MPS CLINIC	0	1,409,408	88.03
90.00	09000	CLINIC	0	537,118	90.00
91.00	09100	EMERGENCY	0	2,000,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	514,684	95.00
101.00	10100	HOME HEALTH AGENCY	0	811,966	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	1,251,483	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,271,231	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,931	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	53,757	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	263,324	194.01
194.02	07952	REFERENCE LAB	0	1,158,335	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	27,770,578	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,146	12,118	1,504	17,768	4.00
5.01	00570	ADMITTING	7,539	3,915	1,275	12,729	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	2,280	6,547	855	9,682	5.02
5.03	00550	DATA PROCESSING	40,045	9,499	41,123	90,667	5.03
5.04	01160	COMMUNICATIONS	0	6,337	0	6,337	5.04
5.05	00590	BUSINESS OFFICE	5,216	9,173	374	14,763	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	58,016	76,689	5,660	140,365	5.06
7.00	00700	OPERATION OF PLANT	548	87,924	78,388	166,860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,564	81	15,645	8.00
9.00	00900	HOUSEKEEPING	646	4,539	90	5,275	9.00
10.00	01000	DIETARY	6,465	23,299	1,512	31,276	10.00
11.00	01100	CAFETERIA	0	7,056	0	7,056	11.00
13.00	01300	NURSING ADMINISTRATION	2,695	5,950	0	8,645	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,211	4,456	14,667	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,869	11,161	54	15,084	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,337	58,431	37,235	100,003	30.00
44.00	04400	SKILLED NURSING FACILITY	2,934	65,236	18,136	86,306	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	51,527	110,541	158,226	320,294	50.00
53.00	05300	ANESTHESIOLOGY	0	2,266	530	2,796	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,369	32,024	61,671	141,064	54.00
57.00	05700	CT SCAN	0	5,251	83,879	89,130	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	266	266	58.00
60.00	06000	LABORATORY	39,943	23,889	16,263	80,095	60.00
65.00	06500	RESPIRATORY THERAPY	24,646	17,023	11,802	53,471	65.00
66.00	06600	PHYSICAL THERAPY	7,942	83,881	22,595	114,418	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,520	4,840	6,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,288	12,701	3,774	20,763	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	6,396	17,641	408	24,445	88.00
88.01	08801	RHC II - MILFORD CLINIC	3,750	18,726	14,174	36,650	88.01
88.02	08802	RHC III - KENTLAND CLINIC	9,261	28,578	7,391	45,230	88.02
88.03	08803	RHC IV - MPS CLINIC	6,680	19,968	11,844	38,492	88.03
90.00	09000	CLINIC	7,400	45,411	2,786	55,597	90.00
91.00	09100	EMERGENCY	4,419	20,117	23,228	47,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	6,995	1,404	28,903	37,302	95.00
101.00	10100	HOME HEALTH AGENCY	2,532	24,615	13,467	40,614	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	37,052	24,615	13,715	75,382	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,936	903,820	670,505	1,973,261	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	100	6,228	0	6,328	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	11,181	0	11,181	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	13,088	3,904	16,992	194.01
194.02	07952	REFERENCE LAB	0	0	2,167	2,167	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	399,036	934,317	676,576	2,009,929	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMITTING	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	13,050					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	9,748				5.02
5.03	00550	DATA PROCESSING	0	57	91,066			5.03
5.04	01160	COMMUNICATIONS	0	0	0	6,337		5.04
5.05	00590	BUSINESS OFFICE	0	12	2,566	184	18,063	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	127	2,819	386	0	5.06
7.00	00700	OPERATION OF PLANT	0	119	2,498	220	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10	366	18	0	8.00
9.00	00900	HOUSEKEEPING	0	175	3,938	18	0	9.00
10.00	01000	DIETARY	0	117	2,438	165	0	10.00
11.00	01100	CAFETERIA	0	84	2,017	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1	1,514	202	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8	2,650	643	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	599	211	8,194	1,269	828	30.00
44.00	04400	SKILLED NURSING FACILITY	629	99	9,176	220	870	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	951	909	3,749	680	1,315	50.00
53.00	05300	ANESTHESIOLOGY	25	25	0	0	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,514	295	3,887	404	2,094	54.00
57.00	05700	CT SCAN	1,659	0	580	0	2,296	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	314	0	383	0	435	58.00
60.00	06000	LABORATORY	2,142	2,905	4,445	294	2,974	60.00
65.00	06500	RESPIRATORY THERAPY	180	166	2,608	184	249	65.00
66.00	06600	PHYSICAL THERAPY	625	30	2,873	18	865	66.00
69.00	06900	ELECTROCARDIOLOGY	128	2	352	73	178	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140	703	0	0	194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215	2,428	0	0	297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,055	111	1,995	147	1,460	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	134	19	1,571	0	185	88.00
88.01	08801	RHC II - MILFORD CLINIC	68	15	1,316	0	94	88.01
88.02	08802	RHC III - KENTLAND CLINIC	209	212	2,335	0	289	88.02
88.03	08803	RHC IV - MPS CLINIC	173	26	2,605	459	239	88.03
90.00	09000	CLINIC	51	64	1,949	312	70	90.00
91.00	09100	EMERGENCY	1,643	262	5,001	349	2,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	237	29	7,343	0	327	95.00
101.00	10100	HOME HEALTH AGENCY	137	38	2,187	0	190	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	222	289	4,672	0	307	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,050	9,610	88,027	6,245	18,063	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	37	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	1	777	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	16	2,237	37	0	194.01
194.02	07952	REFERENCE LAB	0	120	25	18	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,050	9,748	91,066	6,337	18,063	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	144,501					5.06
7.00	00700	OPERATION OF PLANT	7,015	177,061				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	400	3,816	20,306			8.00
9.00	00900	HOUSEKEEPING	2,362	1,113	0	13,236		9.00
10.00	01000	DIETARY	2,743	5,713	0	439	43,153	10.00
11.00	01100	CAFETERIA	1,020	1,730	0	133	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,455	1,459	0	112	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	147	2,504	0	193	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,939	2,737	0	210	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,578	14,327	3,763	1,102	4,425	30.00
44.00	04400	SKILLED NURSING FACILITY	11,578	15,996	7,253	1,230	32,879	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,064	27,102	1,254	2,085	43	50.00
53.00	05300	ANESTHESIOLOGY	75	556	0	43	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,550	7,852	1,609	604	0	54.00
57.00	05700	CT SCAN	2,525	1,288	0	99	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,862	0	0	0	0	58.00
60.00	06000	LABORATORY	10,111	5,858	39	450	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,887	4,174	0	321	0	65.00
66.00	06600	PHYSICAL THERAPY	5,857	20,567	1,539	1,582	0	66.00
69.00	06900	ELECTROCARDIOLOGY	146	373	0	29	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	809	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,687	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,398	3,114	0	239	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	3,765	4,325	0	333	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	2,530	4,592	0	353	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	6,089	7,007	0	539	0	88.02
88.03	08803	RHC IV - MPS CLINIC	7,006	4,896	0	376	0	88.03
90.00	09000	CLINIC	2,058	11,135	448	856	86	90.00
91.00	09100	EMERGENCY	9,220	4,933	4,044	379	534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,611	344	357	26	0	95.00
101.00	10100	HOME HEALTH AGENCY	3,878	6,036	0	464	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,144	6,036	0	464	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,509	169,583	20,306	12,661	37,967	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43	1,527	0	117	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	133	2,742	0	211	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	815	3,209	0	247	5,186	194.01
194.02	07952	REFERENCE LAB	6,001	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	144,501	177,061	20,306	13,236	43,153	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
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	12,208					11.00
13.00	01300	NURSING ADMINISTRATION	67	13,663				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	17,573			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478	0	17	24,080		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,931	5,431	413	1,104	157,638	30.00
44.00	04400	SKILLED NURSING FACILITY	1,950	0	193	1,160	171,268	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	920	2,588	1,778	1,754	373,324	50.00
53.00	05300	ANESTHESIOLOGY	0	0	48	46	3,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	942	0	577	2,793	171,744	54.00
57.00	05700	CT SCAN	440	0	0	3,061	101,306	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108	0	0	580	4,053	58.00
60.00	06000	LABORATORY	981	0	5,680	3,961	120,701	60.00
65.00	06500	RESPIRATORY THERAPY	506	1,423	325	333	68,435	65.00
66.00	06600	PHYSICAL THERAPY	1,030	0	58	1,154	151,475	66.00
69.00	06900	ELECTROCARDIOLOGY	38	0	4	237	7,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,375	258	3,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,749	396	10,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	485	0	217	1,946	42,470	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	0	38	246	35,633	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0	29	125	46,090	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0	415	385	63,576	88.02
88.03	08803	RHC IV - MPS CLINIC	402	0	51	319	56,117	88.03
90.00	09000	CLINIC	275	774	125	93	74,167	90.00
91.00	09100	EMERGENCY	1,226	3,447	513	3,030	85,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	56	436	49,433	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	75	254	54,448	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	565	409	95,234	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,779	13,663	17,301	24,080	1,948,829	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3	0	8,056	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	2	0	15,047	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	175	0	31	0	28,995	194.01
194.02	07952	REFERENCE LAB	254	0	236	0	9,002	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,208	13,663	17,573	24,080	2,009,929	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	DATA PROCESSING			5.03
5.04	01160	COMMUNICATIONS			5.04
5.05	00590	BUSINESS OFFICE			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL			5.06
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	0	157,638	30.00
44.00	04400	SKILLED NURSING FACILITY	0	171,268	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	373,324	50.00
53.00	05300	ANESTHESIOLOGY	0	3,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,744	54.00
57.00	05700	CT SCAN	0	101,306	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,053	58.00
60.00	06000	LABORATORY	0	120,701	60.00
65.00	06500	RESPIRATORY THERAPY	0	68,435	65.00
66.00	06600	PHYSICAL THERAPY	0	151,475	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,470	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - GILMAN CLINIC	0	35,633	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	46,090	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	63,576	88.02
88.03	08803	RHC IV - MPS CLINIC	0	56,117	88.03
90.00	09000	CLINIC	0	74,167	90.00
91.00	09100	EMERGENCY	0	85,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	49,433	95.00
101.00	10100	HOME HEALTH AGENCY	0	54,448	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	95,234	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,948,829	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,056	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	15,047	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	28,995	194.01
194.02	07952	REFERENCE LAB	0	9,002	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,009,929	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	137,707				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,414,952			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,786	3,146	14,337,076		4.00
5.01	00570	ADMITTING	577	2,667	259,250	56,206,236	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	965	1,789	52,977	0	5.02
5.03	00550	DATA PROCESSING	1,400	86,003	276,357	0	5.03
5.04	01160	COMMUNICATIONS	934	0	0	0	5.04
5.05	00590	BUSINESS OFFICE	1,352	783	434,328	0	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	11,303	11,838	648,995	0	5.06
7.00	00700	OPERATION OF PLANT	12,959	163,936	281,388	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	169	40,891	0	8.00
9.00	00900	HOUSEKEEPING	669	189	286,454	0	9.00
10.00	01000	DIETARY	3,434	3,162	211,681	0	10.00
11.00	01100	CAFETERIA	1,040	0	135,394	0	11.00
13.00	01300	NURSING ADMINISTRATION	877	0	167,849	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	9,318	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,645	112	253,548	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,612	77,871	1,178,378	2,580,008	30.00
44.00	04400	SKILLED NURSING FACILITY	9,615	37,928	1,391,885	2,710,129	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,292	330,898	676,213	4,097,375	50.00
53.00	05300	ANESTHESIOLOGY	334	1,108	0	107,340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,720	128,976	451,386	6,524,724	54.00
57.00	05700	CT SCAN	774	175,420	184,107	7,151,497	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	557	84,657	1,355,552	58.00
60.00	06000	LABORATORY	3,521	34,012	618,406	9,197,818	60.00
65.00	06500	RESPIRATORY THERAPY	2,509	24,683	490,495	777,150	65.00
66.00	06600	PHYSICAL THERAPY	12,363	47,253	692,963	2,695,858	66.00
69.00	06900	ELECTROCARDIOLOGY	224	10,122	32,852	553,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	602,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	924,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,872	7,893	436,111	4,547,207	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	2,600	854	461,423	575,928	88.00
88.01	08801	RHC II - MILFORD CLINIC	2,760	29,643	256,339	292,365	88.01
88.02	08802	RHC III - KENTLAND CLINIC	4,212	15,457	698,596	899,442	88.02
88.03	08803	RHC IV - MPS CLINIC	2,943	24,770	866,128	745,218	88.03
90.00	09000	CLINIC	6,693	5,827	221,356	218,218	90.00
91.00	09100	EMERGENCY	2,965	48,577	999,951	7,080,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				46,339	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	207	60,447	294,838	1,019,662	95.00
101.00	10100	HOME HEALTH AGENCY	3,628	28,165	464,302	592,627	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	3,628	28,682	600,797	956,528	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,212	1,402,255	14,150,295	56,206,236	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	1,648	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	1,929	8,165	40,545	0	194.01
194.02	07952	REFERENCE LAB	0	4,532	146,236	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	934,317	676,576	2,166,067	330,749	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.784818	0.478162	0.151082	0.005885	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,768	13,050	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001239	0.000232	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: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		DATA PROCESSING (TIME SPENT)	COMMUNICATIONS (# OF PHONES)	BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING	644,138				5.03
5.04	01160	COMMUNICATIONS	0	345			5.04
5.05	00590	BUSINESS OFFICE	18,147	10	56,206,236		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	19,939	21	0	-2,721,325	25,049,253
7.00	00700	OPERATION OF PLANT	17,669	12	0	0	1,215,974
8.00	00800	LAUNDRY & LINEN SERVICE	2,590	1	0	0	69,343
9.00	00900	HOUSEKEEPING	27,858	1	0	0	409,389
10.00	01000	DIETARY	17,243	9	0	0	475,487
11.00	01100	CAFETERIA	14,267	0	0	0	176,795
13.00	01300	NURSING ADMINISTRATION	10,706	11	0	0	252,257
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	25,418
16.00	01600	MEDICAL RECORDS & LIBRARY	18,745	35	0	0	336,114
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,959	69	2,580,008	0	2,181,864
44.00	04400	SKILLED NURSING FACILITY	64,903	12	2,710,129	0	2,006,973
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,520	37	4,097,375	0	1,224,540
53.00	05300	ANESTHESIOLOGY	0	0	107,340	0	12,933
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,496	22	6,524,724	0	1,308,757
57.00	05700	CT SCAN	4,102	0	7,151,497	0	437,710
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,710	0	1,355,552	0	322,740
60.00	06000	LABORATORY	31,439	16	9,197,818	0	1,752,586
65.00	06500	RESPIRATORY THERAPY	18,445	10	777,150	0	673,818
66.00	06600	PHYSICAL THERAPY	20,322	1	2,695,858	0	1,015,302
69.00	06900	ELECTROCARDIOLOGY	2,490	4	553,310	0	25,345
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	602,995	0	140,279
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	924,853	0	465,847
73.00	07300	DRUGS CHARGED TO PATIENTS	14,112	8	4,547,207	0	1,802,329
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	11,110	0	575,928	0	652,652
88.01	08801	RHC II - MILFORD CLINIC	9,307	0	292,365	0	438,468
88.02	08802	RHC III - KENTLAND CLINIC	16,518	0	899,442	0	1,055,469
88.03	08803	RHC IV - MPS CLINIC	18,427	25	745,218	0	1,214,421
90.00	09000	CLINIC	13,784	17	218,218	0	356,651
91.00	09100	EMERGENCY	35,375	19	7,080,432	0	1,598,216
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	51,941	0	1,019,662	0	452,521
101.00	10100	HOME HEALTH AGENCY	15,468	0	592,627	0	672,226
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	33,048	0	956,528	0	1,064,928
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	622,640	340	56,206,236	-2,721,325	23,837,352
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	7,390
194.00	07950	IROQUOIS WOMENS HEALTH	5,499	0	0	0	23,013
194.01	07951	OTHER NONREIMBURSABLE DEPTS	15,820	2	0	0	141,336
194.02	07952	REFERENCE LAB	179	1	0	0	1,040,162
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	972,162	105,046	569,381		2,721,325
203.00		Unit cost multiplier (Wkst. B, Part I)	1.509245	304.481159	0.010130		0.108639
204.00		Cost to be allocated (per Wkst. B, Part II)	91,066	6,337	18,063		144,501
205.00		Unit cost multiplier (Wkst. B, Part II)	0.141377	18.368116	0.000321		0.005769
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING					5.03
5.04	01160	COMMUNICATIONS					5.04
5.05	00590	BUSINESS OFFICE					5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	106,431				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	182,830			8.00
9.00	00900	HOUSEKEEPING	669	0	103,468		9.00
10.00	01000	DIETARY	3,434	0	3,434	38,788	10.00
11.00	01100	CAFETERIA	1,040	0	1,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	877	0	877	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	0	1,505	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,645	0	1,645	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,612	33,880	8,612	3,977	30.00
44.00	04400	SKILLED NURSING FACILITY	9,615	65,305	9,615	29,554	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,292	11,290	16,292	39	50.00
53.00	05300	ANESTHESIOLOGY	334	0	334	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,720	14,485	4,720	0	54.00
57.00	05700	CT SCAN	774	0	774	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	3,521	355	3,521	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,509	0	2,509	0	65.00
66.00	06600	PHYSICAL THERAPY	12,363	13,860	12,363	0	66.00
69.00	06900	ELECTROCARDIOLOGY	224	0	224	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,872	0	1,872	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	2,600	0	2,600	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	2,760	0	2,760	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	4,212	0	4,212	0	88.02
88.03	08803	RHC IV - MPS CLINIC	2,943	0	2,943	0	88.03
90.00	09000	CLINIC	6,693	4,035	6,693	77	90.00
91.00	09100	EMERGENCY	2,965	36,410	2,965	480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	207	3,210	207	0	95.00
101.00	10100	HOME HEALTH AGENCY	3,628	0	3,628	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	3,628	0	3,628	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,936	182,830	98,973	34,127	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	918	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	1,648	0	1,648	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	1,929	0	1,929	4,661	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,348,076	105,932	462,339	585,984	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.666197	0.579402	4.468425	15.107353	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	177,061	20,306	13,236	43,153	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.663622	0.111065	0.127924	1.112535	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: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00550	DATA PROCESSING				5.03
5.04	01160	COMMUNICATIONS				5.04
5.05	00590	BUSINESS OFFICE				5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL				5.06
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	145,246			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,588,165		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,499	56,206,236	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,746	37,353	2,580,008	30.00
44.00	04400	SKILLED NURSING FACILITY	0	17,414	2,710,129	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,508	160,650	4,097,375	50.00
53.00	05300	ANESTHESIOLOGY	0	4,373	107,340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,120	6,524,724	54.00
57.00	05700	CT SCAN	0	0	7,151,497	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,355,552	58.00
60.00	06000	LABORATORY	0	513,535	9,197,818	60.00
65.00	06500	RESPIRATORY THERAPY	15,126	29,346	777,150	65.00
66.00	06600	PHYSICAL THERAPY	0	5,264	2,695,858	66.00
69.00	06900	ELECTROCARDIOLOGY	0	324	553,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	124,293	602,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	429,179	924,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,646	4,547,207	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - GILMAN CLINIC	0	3,420	575,928	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	2,608	292,365	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	37,530	899,442	88.02
88.03	08803	RHC IV - MPS CLINIC	0	4,613	745,218	88.03
90.00	09000	CLINIC	8,223	11,325	218,218	90.00
91.00	09100	EMERGENCY	36,643	46,339	7,080,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,045	1,019,662	95.00
101.00	10100	HOME HEALTH AGENCY	0	6,790	592,627	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	51,034	956,528	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,246	1,563,700	56,206,236	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	243	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	171	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	2,762	0	194.01
194.02	07952	REFERENCE LAB	0	21,289	0	194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	295,871	53,967	409,239	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.037034	0.033981	0.007281	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,663	17,573	24,080	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.094068	0.011065	0.000428	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

Worksheet C
Part I
Date/Time Prepared:
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,325,538		1,325,538			30.00	
44.00	04400	SKILLED NURSING FACILITY	2,710,129		2,710,129			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	615,531	3,481,844	4,097,375	0.427422	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	25,979	81,361	107,340	0.195565	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,658	6,235,066	6,524,724	0.246138	0.000000	54.00	
57.00	05700	CT SCAN	364,486	6,787,011	7,151,497	0.078069	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,521	1,332,031	1,355,552	0.272628	0.000000	58.00	
60.00	06000	LABORATORY	720,237	8,477,581	9,197,818	0.228872	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	252,922	524,228	777,150	1.076159	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	284,870	2,410,988	2,695,858	0.513125	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	56,374	496,936	553,310	0.066231	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,466	283,529	602,995	0.272196	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	268,450	656,403	924,853	0.581470	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	927,969	3,619,238	4,547,207	0.455769	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	575,928	575,928			88.00	
88.01	08801	RHC II - MILFORD CLINIC	0	292,365	292,365			88.01	
88.02	08802	RHC III - KENTLAND CLINIC	0	899,442	899,442			88.02	
88.03	08803	RHC IV - MPS CLINIC	0	745,218	745,218			88.03	
90.00	09000	CLINIC	0	218,218	218,218	2.461383	0.000000	90.00	
91.00	09100	EMERGENCY	415,473	6,664,959	7,080,432	0.282502	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	152,598	1,101,872	1,254,470	0.860390	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,019,662	1,019,662	0.504759	0.000000	95.00	
101.00	10100	HOME HEALTH AGENCY	0	592,627	592,627			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	956,528	956,528			116.00	
200.00		Subtotal (see instructions)	8,753,201	47,453,035	56,206,236			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	8,753,201	47,453,035	56,206,236			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.427452		50.00
53.00	05300	ANESTHESIOLOGY	0.195565		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246446		54.00
57.00	05700	CT SCAN	0.078069		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.272628		58.00
60.00	06000	LABORATORY	0.228872		60.00
65.00	06500	RESPIRATORY THERAPY	1.076159		65.00
66.00	06600	PHYSICAL THERAPY	0.513125		66.00
69.00	06900	ELECTROCARDIOLOGY	0.066231		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581470		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455769		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - GILMAN CLINIC			88.00
88.01	08801	RHC II - MILFORD CLINIC			88.01
88.02	08802	RHC III - KENTLAND CLINIC			88.02
88.03	08803	RHC IV - MPS CLINIC			88.03
90.00	09000	CLINIC	2.461383		90.00
91.00	09100	EMERGENCY	0.282502		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860390		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.504759		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,817,687		2,817,687	0	2,817,687	30.00
44.00	04400	SKILLED NURSING FACILITY	2,928,534		2,928,534	0	2,928,534	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,751,308		1,751,308	125	1,751,433	50.00
53.00	05300	ANESTHESIOLOGY	20,992		20,992	0	20,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,605,984		1,605,984	2,005	1,607,989	54.00
57.00	05700	CT SCAN	558,309		558,309	0	558,309	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	369,561		369,561	0	369,561	58.00
60.00	06000	LABORATORY	2,105,123		2,105,123	0	2,105,123	60.00
65.00	06500	RESPIRATORY THERAPY	836,337	0	836,337	0	836,337	65.00
66.00	06600	PHYSICAL THERAPY	1,383,312	0	1,383,312	0	1,383,312	66.00
69.00	06900	ELECTROCARDIOLOGY	36,646		36,646	0	36,646	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,133		164,133	0	164,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	537,774		537,774	0	537,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,477		2,072,477	0	2,072,477	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	772,414		772,414	0	772,414	88.00
88.01	08801	RHC II - MILFORD CLINIC	535,613		535,613	0	535,613	88.01
88.02	08802	RHC III - KENTLAND CLINIC	1,250,129		1,250,129	0	1,250,129	88.02
88.03	08803	RHC IV - MPS CLINIC	1,409,408		1,409,408	0	1,409,408	88.03
90.00	09000	CLINIC	537,118		537,118	0	537,118	90.00
91.00	09100	EMERGENCY	2,000,239		2,000,239	0	2,000,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,079,333		1,079,333	0	1,079,333	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	514,684		514,684	0	514,684	95.00
101.00	10100	HOME HEALTH AGENCY	811,966		811,966	0	811,966	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,251,483		1,251,483		1,251,483	116.00
200.00		Subtotal (see instructions)	27,350,564	0	27,350,564	2,130	27,352,694	200.00
201.00		Less Observation Beds	1,079,333		1,079,333		1,079,333	201.00
202.00		Total (see instructions)	26,271,231	0	26,271,231	2,130	26,273,361	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,325,538		1,325,538			30.00	
44.00	04400	SKILLED NURSING FACILITY	2,710,129		2,710,129			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	615,531	3,481,844	4,097,375	0.427422	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	25,979	81,361	107,340	0.195565	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,658	6,235,066	6,524,724	0.246138	0.000000	54.00	
57.00	05700	CT SCAN	364,486	6,787,011	7,151,497	0.078069	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,521	1,332,031	1,355,552	0.272628	0.000000	58.00	
60.00	06000	LABORATORY	720,237	8,477,581	9,197,818	0.228872	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	252,922	524,228	777,150	1.076159	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	284,870	2,410,988	2,695,858	0.513125	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	56,374	496,936	553,310	0.066231	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,466	283,529	602,995	0.272196	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	268,450	656,403	924,853	0.581470	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	927,969	3,619,238	4,547,207	0.455769	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	575,928	575,928	1.341164	0.000000	88.00	
88.01	08801	RHC II - MILFORD CLINIC	0	292,365	292,365	1.832001	0.000000	88.01	
88.02	08802	RHC III - KENTLAND CLINIC	0	899,442	899,442	1.389894	0.000000	88.02	
88.03	08803	RHC IV - MPS CLINIC	0	745,218	745,218	1.891269	0.000000	88.03	
90.00	09000	CLINIC	0	218,218	218,218	2.461383	0.000000	90.00	
91.00	09100	EMERGENCY	415,473	6,664,959	7,080,432	0.282502	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	152,598	1,101,872	1,254,470	0.860390	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,019,662	1,019,662	0.504759	0.000000	95.00	
101.00	10100	HOME HEALTH AGENCY	0	592,627	592,627			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	956,528	956,528			116.00	
200.00		Subtotal (see instructions)	8,753,201	47,453,035	56,206,236			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	8,753,201	47,453,035	56,206,236			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.427452			50.00
53.00	05300	ANESTHESIOLOGY	0.195565			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246446			54.00
57.00	05700	CT SCAN	0.078069			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.272628			58.00
60.00	06000	LABORATORY	0.228872			60.00
65.00	06500	RESPIRATORY THERAPY	1.076159			65.00
66.00	06600	PHYSICAL THERAPY	0.513125			66.00
69.00	06900	ELECTROCARDIOLOGY	0.066231			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581470			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455769			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - GILMAN CLINIC	1.341164			88.00
88.01	08801	RHC II - MILFORD CLINIC	1.832001			88.01
88.02	08802	RHC III - KENTLAND CLINIC	1.389894			88.02
88.03	08803	RHC IV - MPS CLINIC	1.891269			88.03
90.00	09000	CLINIC	2.461383			90.00
91.00	09100	EMERGENCY	0.282502			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860390			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.504759			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,751,308	373,324	1,377,984	0	50.00
53.00	05300	ANESTHESIOLOGY	20,992	3,648	17,344	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,605,984	171,744	1,434,240	0	54.00
57.00	05700	CT SCAN	558,309	101,306	457,003	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	369,561	4,053	365,508	0	58.00
60.00	06000	LABORATORY	2,105,123	120,701	1,984,422	0	60.00
65.00	06500	RESPIRATORY THERAPY	836,337	68,435	767,902	0	65.00
66.00	06600	PHYSICAL THERAPY	1,383,312	151,475	1,231,837	0	66.00
69.00	06900	ELECTROCARDIOLOGY	36,646	7,961	28,685	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,133	3,479	160,654	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	537,774	10,772	527,002	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,477	42,470	2,030,007	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	772,414	35,633	736,781	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	535,613	46,090	489,523	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	1,250,129	63,576	1,186,553	0	88.02
88.03	08803	RHC IV - MPS CLINIC	1,409,408	56,117	1,353,291	0	88.03
90.00	09000	CLINIC	537,118	74,167	462,951	0	90.00
91.00	09100	EMERGENCY	2,000,239	85,857	1,914,382	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,079,333	60,384	1,018,949	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	514,684	49,433	465,251	0	95.00
101.00	10100	HOME HEALTH AGENCY	811,966	54,448	757,518	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,251,483	95,234	1,156,249	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	21,604,343	1,680,307	19,924,036	0	200.00
201.00		Less Observation Beds	1,079,333	60,384	1,018,949	0	201.00
202.00		Total (line 200 minus line 201)	20,525,010	1,619,923	18,905,087	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,751,308	4,097,375	0.427422		50.00
53.00	05300 ANESTHESIOLOGY	20,992	107,340	0.195565		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,605,984	6,524,724	0.246138		54.00
57.00	05700 CT SCAN	558,309	7,151,497	0.078069		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	369,561	1,355,552	0.272628		58.00
60.00	06000 LABORATORY	2,105,123	9,197,818	0.228872		60.00
65.00	06500 RESPIRATORY THERAPY	836,337	777,150	1.076159		65.00
66.00	06600 PHYSICAL THERAPY	1,383,312	2,695,858	0.513125		66.00
69.00	06900 ELECTROCARDIOLOGY	36,646	553,310	0.066231		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164,133	602,995	0.272196		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	537,774	924,853	0.581470		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,072,477	4,547,207	0.455769		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - GILMAN CLINIC	772,414	575,928	1.341164		88.00
88.01	08801 RHC II - MILFORD CLINIC	535,613	292,365	1.832001		88.01
88.02	08802 RHC III - KENTLAND CLINIC	1,250,129	899,442	1.389894		88.02
88.03	08803 RHC IV - MPS CLINIC	1,409,408	745,218	1.891269		88.03
90.00	09000 CLINIC	537,118	218,218	2.461383		90.00
91.00	09100 EMERGENCY	2,000,239	7,080,432	0.282502		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,079,333	1,254,470	0.860390		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	514,684	1,019,662	0.504759		95.00
101.00	10100 HOME HEALTH AGENCY	811,966	592,627	1.370113		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	1,251,483	956,528	1.308360		116.00
200.00	Subtotal (sum of lines 50 thru 199)	21,604,343	52,170,569			200.00
201.00	Less Observation Beds	1,079,333	0			201.00
202.00	Total (line 200 minus line 201)	20,525,010	52,170,569			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		157,638	0	157,638	1,629	96.77	30.00
44.00	SKILLED NURSING FACILITY		171,268		171,268	10,177	16.83	44.00
200.00	Total (lines 30 through 199)		328,906		328,906	11,806		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		698	67,545	30.00			
44.00	SKILLED NURSING FACILITY		1,569	26,406	44.00			
200.00	Total (lines 30 through 199)		2,267	93,951	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

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	PPS	
						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	373,324	4,097,375	0.091113	434,199	39,561	50.00
53.00	05300 ANESTHESIOLOGY	3,648	107,340	0.033985	19,033	647	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	171,744	6,524,724	0.026322	282,005	7,423	54.00
57.00	05700 CT SCAN	101,306	7,151,497	0.014166	362,652	5,137	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4,053	1,355,552	0.002990	23,521	70	58.00
60.00	06000 LABORATORY	120,701	9,197,818	0.013123	711,417	9,336	60.00
65.00	06500 RESPIRATORY THERAPY	68,435	777,150	0.088059	223,973	19,723	65.00
66.00	06600 PHYSICAL THERAPY	151,475	2,695,858	0.056188	59,262	3,330	66.00
69.00	06900 ELECTROCARDIOLOGY	7,961	553,310	0.014388	56,192	808	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,479	602,995	0.005770	317,032	1,829	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,772	924,853	0.011647	202,242	2,356	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	42,470	4,547,207	0.009340	764,380	7,139	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - GILMAN CLINIC	35,633	575,928	0.061871	0	0	88.00
88.01	08801 RHC II - MILFORD CLINIC	46,090	292,365	0.157645	0	0	88.01
88.02	08802 RHC III - KENTLAND CLINIC	63,576	899,442	0.070684	0	0	88.02
88.03	08803 RHC IV - MPS CLINIC	56,117	745,218	0.075303	0	0	88.03
90.00	09000 CLINIC	74,167	218,218	0.339876	0	0	90.00
91.00	09100 EMERGENCY	85,857	7,080,432	0.012126	411,588	4,991	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	60,384	1,254,470	0.048135	152,598	7,345	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,481,192	49,601,752		4,020,094	109,695	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/27/2020 12:49 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,629	0.00	698	0.00	698	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	10,177	0.00	1,569	0.00	1,569	44.00	
200.00		Total (lines 30 through 199)	0	0	11,806	0.00	2,267	0.00	2,267	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:49 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	0	0	0	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0	0	0	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0	0	0	0	88.02
88.03	08803	RHC IV - MPS CLINIC	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:49 pm

				Title XVIII		Hospital	PPS		
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,097,375	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	107,340	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,524,724	0.000000	54.00	
57.00	05700	CT SCAN	0	0	0	7,151,497	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,355,552	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	9,197,818	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	777,150	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	2,695,858	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	553,310	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	602,995	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	924,853	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,547,207	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	0	0	575,928	0.000000	88.00	
88.01	08801	RHC II - MILFORD CLINIC	0	0	0	292,365	0.000000	88.01	
88.02	08802	RHC III - KENTLAND CLINIC	0	0	0	899,442	0.000000	88.02	
88.03	08803	RHC IV - MPS CLINIC	0	0	0	745,218	0.000000	88.03	
90.00	09000	CLINIC	0	0	0	218,218	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	7,080,432	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,254,470	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	49,601,752		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		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	434,199	0	1,265,960	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	19,033	0	21,187	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	282,005	0	2,597,758	0	54.00
57.00	05700	CT SCAN	0.000000	362,652	0	2,550,431	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	23,521	0	570,107	0	58.00
60.00	06000	LABORATORY	0.000000	711,417	0	1,546,623	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	223,973	0	237,369	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	59,262	0	11,512	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	56,192	0	226,710	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	317,032	0	253,402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	202,242	0	322,496	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	764,380	0	1,826,793	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0.000000	0	0	0	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0.000000	0	0	0	0	88.02
88.03	08803	RHC IV - MPS CLINIC	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	63,471	0	90.00
91.00	09100	EMERGENCY	0.000000	411,588	0	2,017,515	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	152,598	0	578,701	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,020,094	0	14,090,035	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 12:49 pm

			Title XVIII		Hospital		PPS	
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	0.427422	1,265,960	0	0	541,099	50.00
53.00	05300	ANESTHESIOLOGY	0.195565	21,187	0	0	4,143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246138	2,597,758	0	0	639,407	54.00
57.00	05700	CT SCAN	0.078069	2,550,431	0	0	199,110	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.272628	570,107	0	0	155,427	58.00
60.00	06000	LABORATORY	0.228872	1,546,623	0	0	353,979	60.00
65.00	06500	RESPIRATORY THERAPY	1.076159	237,369	0	0	255,447	65.00
66.00	06600	PHYSICAL THERAPY	0.513125	11,512	0	0	5,907	66.00
69.00	06900	ELECTROCARDIOLOGY	0.066231	226,710	0	0	15,015	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196	253,402	0	0	68,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581470	322,496	0	0	187,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455769	1,826,793	0	42,561	832,596	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0.000000				0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0.000000				0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0.000000				0	88.02
88.03	08803	RHC IV - MPS CLINIC	0.000000				0	88.03
90.00	09000	CLINIC	2.461383	63,471	0	0	156,226	90.00
91.00	09100	EMERGENCY	0.282502	2,017,515	0	43	569,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860390	578,701	0	0	497,909	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.504759		0			95.00
200.00		Subtotal (see instructions)		14,090,035	0	42,604	4,482,714	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		14,090,035	0	42,604	4,482,714	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 12:49 pm

				Title XVIII	Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,398		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - GILMAN CLINIC	0	0		88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0		88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0		88.02
88.03	08803	RHC IV - MPS CLINIC	0	0		88.03
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	12		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	19,410		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	19,410		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:

Worksheet D

Component CCN: 14-U167

From 10/01/2018

Part V

To 09/30/2019

Date/Time Prepared:

2/27/2020 12:49 pm

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	0.427422	0	0	0
53.00	05300	ANESTHESIOLOGY	0.195565	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246138	0	0	0
57.00	05700	CT SCAN	0.078069	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.272628	0	0	0
60.00	06000	LABORATORY	0.228872	0	0	0
65.00	06500	RESPIRATORY THERAPY	1.076159	0	0	0
66.00	06600	PHYSICAL THERAPY	0.513125	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.066231	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581470	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455769	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - GILMAN CLINIC	0.000000			0
88.01	08801	RHC II - MILFORD CLINIC	0.000000			0
88.02	08802	RHC III - KENTLAND CLINIC	0.000000			0
88.03	08803	RHC IV - MPS CLINIC	0.000000			0
90.00	09000	CLINIC	2.461383	0	0	0
91.00	09100	EMERGENCY	0.282502	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860390	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.504759		0	
200.00		Subtotal (see instructions)		0	0	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	
202.00		Net Charges (line 200 - line 201)		0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:

Worksheet D

Component CCN: 14-U167

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 12:49 pm

				Title XVIII	Swing Beds - SNF	PPS
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - GILMAN CLINIC	0	0		88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0		88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0		88.02
88.03	08803	RHC IV - MPS CLINIC	0	0		88.03
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0167 Component CCN: 14-6049		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:49 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC - GILMAN CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0	0	0	0	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0	0	0	0	0	88.02
88.03	08803	RHC IV - MPS CLINIC	0	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0167 Component CCN: 14-6049		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:49 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	4,097,375	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	107,340	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	6,524,724	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	7,151,497	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	1,355,552	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	9,197,818	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	777,150	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,695,858	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	553,310	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	602,995	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	924,853	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	4,547,207	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC - GILMAN CLINIC		0	0	0	575,928	0.000000	88.00
88.01	08801	RHC II - MILFORD CLINIC		0	0	0	292,365	0.000000	88.01
88.02	08802	RHC III - KENTLAND CLINIC		0	0	0	899,442	0.000000	88.02
88.03	08803	RHC IV - MPS CLINIC		0	0	0	745,218	0.000000	88.03
90.00	09000	CLINIC		0	0	0	218,218	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	7,080,432	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,254,470	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	49,601,752		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0167 Component CCN: 14-6049		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 12:49 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,690	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	3,350	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,029	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	225,608	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,868	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	78,552	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC - GILMAN CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0.000000	0	0	0	0	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0.000000	0	0	0	0	0	88.02
88.03	08803	RHC IV - MPS CLINIC	0.000000	0	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			316,097	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		157,638	0	157,638	1,629	96.77	30.00
44.00	SKILLED NURSING FACILITY		171,268		171,268	10,177	16.83	44.00
200.00	Total (lines 30 through 199)		328,906		328,906	11,806		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		6	581				
44.00	SKILLED NURSING FACILITY		0	0				
200.00	Total (lines 30 through 199)		6	581				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	373,324	4,097,375	0.091113	0	50.00
53.00	05300	ANESTHESIOLOGY	3,648	107,340	0.033985	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,744	6,524,724	0.026322	3,279	54.00
57.00	05700	CT SCAN	101,306	7,151,497	0.014166	1,834	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,053	1,355,552	0.002990	0	58.00
60.00	06000	LABORATORY	120,701	9,197,818	0.013123	5,470	60.00
65.00	06500	RESPIRATORY THERAPY	68,435	777,150	0.088059	193	65.00
66.00	06600	PHYSICAL THERAPY	151,475	2,695,858	0.056188	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,961	553,310	0.014388	182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,479	602,995	0.005770	566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,772	924,853	0.011647	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,470	4,547,207	0.009340	9,916	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	35,633	575,928	0.061871	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	46,090	292,365	0.157645	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	63,576	899,442	0.070684	0	88.02
88.03	08803	RHC IV - MPS CLINIC	56,117	745,218	0.075303	0	88.03
90.00	09000	CLINIC	74,167	218,218	0.339876	0	90.00
91.00	09100	EMERGENCY	85,857	7,080,432	0.012126	3,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	60,384	1,254,470	0.048135	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	1,481,192	49,601,752		25,325	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/27/2020 12:49 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	1,629	0.00	6	30.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	10,177	0.00	0	44.00		
200.00		Total (lines 30 through 199)	0	0	11,806		6	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							
44.00	04400	SKILLED NURSING FACILITY	0							
200.00		Total (lines 30 through 199)	0							

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description			Title XIX		Hospital		PPS	
			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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	0	0	0	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0	0	0	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0	0	0	0	88.02
88.03	08803	RHC IV - MPS CLINIC	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:49 pm

				Title XIX		Hospital	PPS		
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,097,375	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	107,340	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,524,724	0.000000	54.00	
57.00	05700	CT SCAN	0	0	0	7,151,497	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,355,552	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	9,197,818	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	777,150	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	2,695,858	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	553,310	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	602,995	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	924,853	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,547,207	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - GILMAN CLINIC	0	0	0	575,928	0.000000	88.00	
88.01	08801	RHC II - MILFORD CLINIC	0	0	0	292,365	0.000000	88.01	
88.02	08802	RHC III - KENTLAND CLINIC	0	0	0	899,442	0.000000	88.02	
88.03	08803	RHC IV - MPS CLINIC	0	0	0	745,218	0.000000	88.03	
90.00	09000	CLINIC	0	0	0	218,218	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	7,080,432	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,254,470	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	49,601,752		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,279	0	0	54.00
57.00	05700	CT SCAN	0.000000	1,834	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	5,470	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	193	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	182	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	566	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,916	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	0.000000	0	0	0	88.00
88.01	08801	RHC II - MILFORD CLINIC	0.000000	0	0	0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	0.000000	0	0	0	88.02
88.03	08803	RHC IV - MPS CLINIC	0.000000	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,885	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		25,325	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 12:49 pm

			Title XIX		Hospital		PPS	
	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	0.427422	0	66,445	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.195565	0	2,257	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246138	0	123,741	0	0	54.00
57.00	05700	CT SCAN	0.078069	0	220,160	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.272628	0	50,217	0	0	58.00
60.00	06000	LABORATORY	0.228872	0	143,731	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.076159	0	5,015	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.513125	0	16,890	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.066231	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196	0	17,344	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581470	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455769	0	41,217	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - GILMAN CLINIC	1.341164				0	88.00
88.01	08801	RHC II - MILFORD CLINIC	1.832001				0	88.01
88.02	08802	RHC III - KENTLAND CLINIC	1.389894				0	88.02
88.03	08803	RHC IV - MPS CLINIC	1.891269				0	88.03
90.00	09000	CLINIC	2.461383	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.282502	0	341,255	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860390	0	16,977	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.504759	0	0			95.00
200.00		Subtotal (see instructions)		0	1,045,249	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,045,249	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0167		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/27/2020 12:49 pm	
				Title XIX		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	28,400	0					50.00
53.00	05300	ANESTHESIOLOGY	441	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,457	0					54.00
57.00	05700	CT SCAN	17,188	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,691	0					58.00
60.00	06000	LABORATORY	32,896	0					60.00
65.00	06500	RESPIRATORY THERAPY	5,397	0					65.00
66.00	06600	PHYSICAL THERAPY	8,667	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,721	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,785	0					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC - GILMAN CLINIC	0	0					88.00
88.01	08801	RHC II - MILFORD CLINIC	0	0					88.01
88.02	08802	RHC III - KENTLAND CLINIC	0	0					88.02
88.03	08803	RHC IV - MPS CLINIC	0	0					88.03
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	96,405	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,607	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	271,655	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	271,655	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:49 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,629 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,629 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)			1,005 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			698 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			224.47 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			231.33 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			159.97 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.97 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,817,687 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,817,687 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,817,687 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)			1,729.70 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,207,331 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)			1,207,331 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XVIII		Hospital		PPS
		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)					1,531,371 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,738,702 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)					67,545 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					109,695 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					177,240 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,561,462 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)					624 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,729.70 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,079,333 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		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	157,638	2,817,687	0.055946	1,079,333	60,384	90.00
91.00	Nursing School cost	0	2,817,687	0.000000	1,079,333	0	91.00
92.00	Allied health cost	0	2,817,687	0.000000	1,079,333	0	92.00
93.00	All other Medical Education	0	2,817,687	0.000000	1,079,333	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:49 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,177	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,177	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)		10,177	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,569	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		224.47	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		231.33	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,928,534	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,928,534	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,928,534	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:49 pm
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					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)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					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					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)				2,928,534	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				287.76	71.00
72.00 Program routine service cost (line 9 x line 71)				451,495	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				451,495	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				451,495	83.00
84.00 Program inpatient ancillary services (see instructions)				157,011	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				608,506	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

Period:

Worksheet D-1

Component CCN: 14-6049

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

Title XVIII

Skilled Nursing
Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 12:49 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,629 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,629 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)			1,005 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			6 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			224.47 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			231.33 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			159.97 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.97 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,817,687 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,817,687 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,817,687 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)			1,729.70 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			10,378 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)			10,378 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XIX		Hospital		PPS
		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)					8,194 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,572 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)					581 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					347 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					928 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,644 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)					624 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,729.70 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,079,333 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	157,638	2,817,687	0.055946	1,079,333	60,384
91.00	Nursing School cost	0	2,817,687	0.000000	1,079,333	0
92.00	Allied health cost	0	2,817,687	0.000000	1,079,333	0
93.00	All other Medical Education	0	2,817,687	0.000000	1,079,333	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:49 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		864,752		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.427452	434,199	185,599	50.00
53.00	05300 ANESTHESIOLOGY	0.195565	19,033	3,722	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246446	282,005	69,499	54.00
57.00	05700 CT SCAN	0.078069	362,652	28,312	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.272628	23,521	6,412	58.00
60.00	06000 LABORATORY	0.228872	711,417	162,823	60.00
65.00	06500 RESPIRATORY THERAPY	1.076159	223,973	241,031	65.00
66.00	06600 PHYSICAL THERAPY	0.513125	59,262	30,409	66.00
69.00	06900 ELECTROCARDIOLOGY	0.066231	56,192	3,722	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196	317,032	86,295	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.581470	202,242	117,598	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.455769	764,380	348,381	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - GILMAN CLINIC	0.000000		0	88.00
88.01	08801 RHC II - MILFORD CLINIC	0.000000		0	88.01
88.02	08802 RHC III - KENTLAND CLINIC	0.000000		0	88.02
88.03	08803 RHC IV - MPS CLINIC	0.000000		0	88.03
90.00	09000 CLINIC	2.461383	0	0	90.00
91.00	09100 EMERGENCY	0.282502	411,588	116,274	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.860390	152,598	131,294	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)		4,020,094	1,531,371	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		4,020,094		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.427452	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.195565	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246446	3,690	909	54.00
57.00	05700 CT SCAN	0.078069	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.272628	0	0	58.00
60.00	06000 LABORATORY	0.228872	3,350	767	60.00
65.00	06500 RESPIRATORY THERAPY	1.076159	3,029	3,260	65.00
66.00	06600 PHYSICAL THERAPY	0.513125	225,608	115,765	66.00
69.00	06900 ELECTROCARDIOLOGY	0.066231	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196	1,868	508	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.581470	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.455769	78,552	35,802	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - GILMAN CLINIC	0.000000		0	88.00
88.01	08801 RHC II - MILFORD CLINIC	0.000000		0	88.01
88.02	08802 RHC III - KENTLAND CLINIC	0.000000		0	88.02
88.03	08803 RHC IV - MPS CLINIC	0.000000		0	88.03
90.00	09000 CLINIC	2.461383	0	0	90.00
91.00	09100 EMERGENCY	0.282502	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.860390	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)		316,097	157,011	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)		316,097		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 12:49 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		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		5,863		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.427452	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.195565	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246446	3,279	808	54.00
57.00	05700 CT SCAN	0.078069	1,834	143	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.272628	0	0	58.00
60.00	06000 LABORATORY	0.228872	5,470	1,252	60.00
65.00	06500 RESPIRATORY THERAPY	1.076159	193	208	65.00
66.00	06600 PHYSICAL THERAPY	0.513125	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.066231	182	12	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.272196	566	154	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.581470	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.455769	9,916	4,519	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - GILMAN CLINIC	1.341164	0	0	88.00
88.01	08801 RHC II - MILFORD CLINIC	1.832001	0	0	88.01
88.02	08802 RHC III - KENTLAND CLINIC	1.389894	0	0	88.02
88.03	08803 RHC IV - MPS CLINIC	1.891269	0	0	88.03
90.00	09000 CLINIC	2.461383	0	0	90.00
91.00	09100 EMERGENCY	0.282502	3,885	1,098	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.860390	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)		25,325	8,194	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)		25,325		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 12:49 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,603,531	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		23.29	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.79	30.00
31.00	Percentage of Medicaid patient days (see instructions)		10.85	31.00
32.00	Sum of lines 30 and 31		15.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)		2.92	33.00
34.00	Disproportionate share adjustment (see instructions)		11,706	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0	0.000031225	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	251,339	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	251,339	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		251,339		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	1,866,576			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	2,063,410			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			2,063,410	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			130,163	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,193,573	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,193,573	61.00
62.00	Deductibles billed to program beneficiaries			239,176	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			13,640	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			8,866	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,640	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1,963,263	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-4,169	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 12:49 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	535,929	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,495,023	71.00
71.01	Sequestration adjustment (see instructions)		49,900	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		2,423,237	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		21,886	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		23,632	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/27/2020 12:49 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,603,531	0		1,603,531	1,603,531	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0292	0.0292	0.0292	0.0292		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	11,706	0	0	11,706	11,706	11.00
11.01	Uncompensated care payments	36.00	251,339	0	0	251,339	251,339	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,866,576	0	0	1,866,576	1,866,576	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,063,410	0	0	2,063,410	2,063,410	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,063,410	0	0	2,063,410	2,063,410	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	130,163	0	0	130,163	130,163	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/27/2020 12:49 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	2,193,573	2,193,573
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	130,163	0	0	130,163	130,163
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	130,163	0	0	130,163	130,163
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.244318	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				535,929	535,929
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2020 12:49 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,603,531		1,603,531	1,603,531	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0292	0.0292	0.0292		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	11,706	0	11,706	11,706	11.00
11.01	Uncompensated care payments	36.00	251,339	0	251,339	251,339	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,866,576	0	1,866,576	1,866,576	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,063,410	0	2,063,410	2,063,410	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,063,410	0	2,063,410	2,063,410	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	130,163	0	130,163	130,163	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,193,573	2,193,573	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2020 12:49 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	130,163	0	130,163	130,163	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	130,163	0	130,163	130,163	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	535,929		535,929	535,929	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,169	0	-4,169	-4,169	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		19,410	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,482,714	2.00	
3.00	OPPS payments		3,087,402	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)		19,410	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		42,604	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)		42,604	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)		42,604	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		23,194	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)		19,410	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)		3,087,402	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		604,425	26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,502,387	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00	
30.00	Subtotal (sum of lines 27 through 29)		2,502,387	30.00	
31.00	Primary payer payments		578	31.00	
32.00	Subtotal (line 30 minus line 31)		2,501,809	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)		38,524	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		25,041	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		38,524	36.00	
37.00	Subtotal (see instructions)		2,526,850	37.00	
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99	
40.00	Subtotal (see instructions)		2,526,850	40.00	
40.01	Sequestration adjustment (see instructions)		50,537	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
41.00	Interim payments		2,469,168	41.00	
42.00	Tentative settlement (for contractors use only)		0	42.00	
43.00	Balance due provider/program (see instructions)		7,145	43.00	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35,095	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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/27/2020 12:49 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,436,114		2,512,087	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	05/15/2019	12,877	05/15/2019	42,919	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)		-12,877		-42,919	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,423,237		2,469,168	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		21,886		7,145	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,445,123		2,476,313	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: 14-0167

Period:

Worksheet E-1

Component CCN: 14-U167

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pm

		Title XVIII		Swing Beds - SNF		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	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: 14-0167
 Component CCN: 14-6049

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2020 12:49 pm

Title XVIII

 Skilled Nursing
 Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		512,518		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)		512,518		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		512,518		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: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0167

Period:

Worksheet E-2

Component CCN: 14-U167

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/27/2020 12:49 pm

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	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, see instructions)			0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	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)		0	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%)				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	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)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		0	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
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: 14-0167 Component CCN: 14-6049	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 2/27/2020 12:49 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		683,490	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		683,490	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		160,512	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		522,978	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		522,978	15.00
15.01	Sequestration adjustment (see instructions)		10,460	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		512,518	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2020 12:49 pm
		Title XIX	Hospital	PPS
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		271,655	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	271,655	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	271,655	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	25,325	1,045,249	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)	25,325	1,045,249	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)	25,325	1,045,249	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	25,325	773,594	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	271,655	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	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	271,655	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	271,655	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	271,655	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	271,655	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	271,655	40.00
41.00	Interim payments	0	271,655	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/27/2020 12:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	428,838	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,018,442	0	0	0	4.00
5.00	Other receivable	1,109,757	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,913,879	0	0	0	6.00
7.00	Inventory	846,060	0	0	0	7.00
8.00	Prepaid expenses	371,069	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	63,034	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,923,321	0	0	0	11.00
FIXED ASSETS						
12.00	Land	337,950	0	0	0	12.00
13.00	Land improvements	483,553	0	0	0	13.00
14.00	Accumulated depreciation	-479,710	0	0	0	14.00
15.00	Buildings	25,914,340	0	0	0	15.00
16.00	Accumulated depreciation	-18,836,224	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	16,002,690	0	0	0	19.00
20.00	Accumulated depreciation	-14,000,687	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)	9,421,912	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	24,543	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,833,657	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,858,200	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,203,433	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,543,110	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,104,857	0	0	0	38.00
39.00	Payroll taxes payable	-10,960	0	0	0	39.00
40.00	Notes and loans payable (short term)	420,983	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,057,990	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,385,159	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)	3,385,159	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,443,149	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,760,284				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)	10,760,284	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,203,433	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/27/2020 12:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,782,041		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,021,757				2.00
3.00	Total (sum of line 1 and line 2)		10,760,284		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)		10,760,284		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,760,284		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,553,701		3,553,701	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	2,716,921		2,716,921	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)	6,270,622		6,270,622	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)	6,270,622		6,270,622	17.00
18.00	Ancillary services	3,564,677	52,065,229	55,629,906	18.00
19.00	Outpatient services	0	148	148	19.00
20.00	RHC - GILMAN CLINIC	0	575,928	575,928	20.00
20.01	RHC II - MILFORD CLINIC	0	292,365	292,365	20.01
20.02	RHC III - KENTLAND CLINIC	0	899,442	899,442	20.02
20.03	RHC IV - MPS CLINIC	0	745,218	745,218	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		592,627	592,627	22.00
23.00	AMBULANCE SERVICES	0	1,019,662	1,019,662	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	956,528	956,528	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,835,299	57,147,147	66,982,446	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,090,700		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)		33,090,700		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/27/2020 12:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,982,446	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,693,348	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,289,098	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,090,700	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,801,602	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,423,080	6.00
7.00	Income from investments	146,518	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	132,948	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	180,710	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR GRANT	0	24.00
24.01	340B INCOME/LOSS	1,026,849	24.01
24.02	MISC NON-PATIENT REVENUE	115,454	24.02
24.03	AMBULANCE SUBSIDY	11,074	24.03
24.04	OTHER MISCELLANEOUS REVENUE	-1,256,788	24.04
25.00	Total other income (sum of lines 6-24)	1,779,845	25.00
26.00	Total (line 5 plus line 25)	-6,021,757	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)	-6,021,757	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0167

Period:

Worksheet H

HHA CCN: 14-7586

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/27/2020 12:49 pm

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	19,469	0	0	19,469	4.00
5.00 Administrative and General	104,748	-156	0	38,651	23,266	166,509	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	227,715	-340	0	0	0	227,375	6.00
7.00 Physical Therapy	59,206	-88	0	0	0	59,118	7.00
8.00 Occupational Therapy	9,109	-14	0	0	0	9,095	8.00
9.00 Speech Pathology	911	-1	0	0	0	910	9.00
10.00 Medical Social Services	364	-1	0	0	0	363	10.00
11.00 Home Health Aide	53,377	-80	0	0	0	53,297	11.00
12.00 Supplies (see instructions)	0	0	0	0	6,790	6,790	12.00
13.00 Drugs	0	0	0	0	210	210	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	455,430	-680	19,469	38,651	30,266	543,136	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	-12,322	7,147	0	7,147			4.00
5.00 Administrative and General	0	166,509	0	166,509			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	227,375	0	227,375			6.00
7.00 Physical Therapy	0	59,118	0	59,118			7.00
8.00 Occupational Therapy	0	9,095	0	9,095			8.00
9.00 Speech Pathology	0	910	0	910			9.00
10.00 Medical Social Services	0	363	0	363			10.00
11.00 Home Health Aide	0	53,297	0	53,297			11.00
12.00 Supplies (see instructions)	0	6,790	0	6,790			12.00
13.00 Drugs	0	210	0	210			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	-12,322	530,814	0	530,814			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0167

Period:

Worksheet H-1

HHA CCN: 14-7586

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

Home Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	7,147	0	0	0	7,147		4.00
5.00	Administrative and General	166,509	0	0	0	7,147	173,656	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	227,375	0	0	0	0	227,375	6.00
7.00	Physical Therapy	59,118	0	0	0	0	59,118	7.00
8.00	Occupational Therapy	9,095	0	0	0	0	9,095	8.00
9.00	Speech Pathology	910	0	0	0	0	910	9.00
10.00	Medical Social Services	363	0	0	0	0	363	10.00
11.00	Home Health Aide	53,297	0	0	0	0	53,297	11.00
12.00	Supplies (see instructions)	6,790	0	0	0	0	6,790	12.00
13.00	Drugs	210	0	0	0	0	210	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	530,814	0	0	0	7,147	530,814	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	173,656						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	110,555	337,930					6.00
7.00	Physical Therapy	28,744	87,862					7.00
8.00	Occupational Therapy	4,422	13,517					8.00
9.00	Speech Pathology	442	1,352					9.00
10.00	Medical Social Services	176	539					10.00
11.00	Home Health Aide	25,914	79,211					11.00
12.00	Supplies (see instructions)	3,301	10,091					12.00
13.00	Drugs	102	312					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		530,814					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-1

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:49 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,628			0		1.00
2.00	Capital Related - Movable Equipment		28,165		0		2.00
3.00	Plant Operation & Maintenance	0	0	3,628	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	3,628	28,165	3,628	100	-173,656	357,158 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	227,375 6.00
7.00	Physical Therapy	0	0	0	0	0	59,118 7.00
8.00	Occupational Therapy	0	0	0	0	0	9,095 8.00
9.00	Speech Pathology	0	0	0	0	0	910 9.00
10.00	Medical Social Services	0	0	0	0	0	363 10.00
11.00	Home Health Aide	0	0	0	0	0	53,297 11.00
12.00	Supplies (see instructions)	0	0	0	0	0	6,790 12.00
13.00	Drugs	0	0	0	0	0	210 13.00
14.00	DME	0	0	0	0	0	0 14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0 15.00
16.00	Respiratory Therapy	0	0	0	0	0	0 16.00
17.00	Private Duty Nursing	0	0	0	0	0	0 17.00
18.00	Clinic	0	0	0	0	0	0 18.00
19.00	Health Promotion Activities	0	0	0	0	0	0 19.00
20.00	Day Care Program	0	0	0	0	0	0 20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0 21.00
22.00	Homemaker Service	0	0	0	0	0	0 22.00
23.00	All Others (specify)	0	0	0	0	0	0 23.00
23.50	Telemedicine	0	0	0	0	0	0 23.50
24.00	Total (sum of lines 1-23)	3,628	28,165	3,628	100	-173,656	357,158 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	7,147		173,656 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	71.470000		0.486216 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	24,615	13,467	16,134	3,488	346	1.00
2.00	Skilled Nursing Care	337,930	0	0	35,075	0	0	2.00
3.00	Physical Therapy	87,862	0	0	9,119	0	0	3.00
4.00	Occupational Therapy	13,517	0	0	1,403	0	0	4.00
5.00	Speech Pathology	1,352	0	0	140	0	0	5.00
6.00	Medical Social Services	539	0	0	56	0	0	6.00
7.00	Home Health Aide	79,211	0	0	8,221	0	0	7.00
8.00	Supplies (see instructions)	10,091	0	0	0	0	0	8.00
9.00	Drugs	312	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	530,814	24,615	13,467	70,148	3,488	346	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	5A.05	5.06	7.00	
1.00	Administrative and General	23,345	0	6,003	87,398	9,495	45,953	1.00
2.00	Skilled Nursing Care	0	0	0	373,005	40,522	0	2.00
3.00	Physical Therapy	0	0	0	96,981	10,536	0	3.00
4.00	Occupational Therapy	0	0	0	14,920	1,621	0	4.00
5.00	Speech Pathology	0	0	0	1,492	162	0	5.00
6.00	Medical Social Services	0	0	0	595	65	0	6.00
7.00	Home Health Aide	0	0	0	87,432	9,499	0	7.00
8.00	Supplies (see instructions)	0	0	0	10,091	1,096	0	8.00
9.00	Drugs	0	0	0	312	34	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	23,345	0	6,003	672,226	73,030	45,953	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pmHome Health
Agency I

PPS

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	16,211	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	231	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	16,211	0	0	0	231	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	4,315	163,372	0	163,372			1.00
2.00	Skilled Nursing Care	0	413,527	0	413,527	104,162	517,689	2.00
3.00	Physical Therapy	0	107,517	0	107,517	27,082	134,599	3.00
4.00	Occupational Therapy	0	16,541	0	16,541	4,166	20,707	4.00
5.00	Speech Pathology	0	1,654	0	1,654	417	2,071	5.00
6.00	Medical Social Services	0	660	0	660	166	826	6.00
7.00	Home Health Aide	0	96,931	0	96,931	24,416	121,347	7.00
8.00	Supplies (see instructions)	0	11,418	0	11,418	2,876	14,294	8.00
9.00	Drugs	0	346	0	346	87	433	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,315	811,966	0	811,966	163,372	811,966	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.251886		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:49 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	DATA PROCESSING (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	3,628	28,165	106,789	592,627	6,790	15,468	1.00
2.00	Skilled Nursing Care	0	0	232,152	0	0	0	2.00
3.00	Physical Therapy	0	0	60,359	0	0	0	3.00
4.00	Occupational Therapy	0	0	9,286	0	0	0	4.00
5.00	Speech Pathology	0	0	928	0	0	0	5.00
6.00	Medical Social Services	0	0	371	0	0	0	6.00
7.00	Home Health Aide	0	0	54,417	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,628	28,165	464,302	592,627	6,790	15,468	20.00
21.00	Total cost to be allocated	24,615	13,467	70,148	3,488	346	23,345	21.00
22.00	Unit cost multiplier	6.784730	0.478147	0.151083	0.005886	0.050957	1.509245	22.00
Cost Center Description		COMMUNICATIONS	BUSINESS OFFICE	Reconciliation	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		(# OF PHONES)	(GROSS CHARGES)		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	
		5.04	5.05	5A.06	5.06	7.00	8.00	
1.00	Administrative and General	0	592,627	0	87,398	3,628	0	1.00
2.00	Skilled Nursing Care	0	0	0	373,005	0	0	2.00
3.00	Physical Therapy	0	0	0	96,981	0	0	3.00
4.00	Occupational Therapy	0	0	0	14,920	0	0	4.00
5.00	Speech Pathology	0	0	0	1,492	0	0	5.00
6.00	Medical Social Services	0	0	0	595	0	0	6.00
7.00	Home Health Aide	0	0	0	87,432	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	10,091	0	0	8.00
9.00	Drugs	0	0	0	312	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	592,627		672,226	3,628	0	20.00
21.00	Total cost to be allocated	0	6,003		73,030	45,953	0	21.00
22.00	Unit cost multiplier	0.000000	0.010129		0.108639	12.666207	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:49 pmHome Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	3,628	0	0	0	0	592,627	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	6,790	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,628	0	0	0	6,790	592,627	20.00
21.00	Total cost to be allocated	16,211	0	0	0	231	4,315	21.00
22.00	Unit cost multiplier	4.468302	0.000000	0.000000	0.000000	0.034021	0.007281	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/27/2020 12:49 pm

Title XVIII

Home Health

PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	517,689		517,689	1,929	268.37	1.00
2.00	Physical Therapy	3.00	134,599	0	134,599	1,122	119.96	2.00
3.00	Occupational Therapy	4.00	20,707	0	20,707	184	112.54	3.00
4.00	Speech Pathology	5.00	2,071	0	2,071	13	159.31	4.00
5.00	Medical Social Services	6.00	826		826	13	63.54	5.00
6.00	Home Health Aide	7.00	121,347		121,347	518	234.26	6.00
7.00	Total (sum of lines 1-6)		797,239	0	797,239	3,779		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		16580	0	102			8.00
8.01	Skilled Nursing Care		19180	0	157			8.01
8.02	Skilled Nursing Care		99914	0	1,106			8.02
9.00	Physical Therapy		16580	0	38			9.00
9.01	Physical Therapy		19180	0	18			9.01
9.02	Physical Therapy		99914	0	707			9.02
10.00	Occupational Therapy		16580	0	1			10.00
10.01	Occupational Therapy		19180	0	1			10.01
10.02	Occupational Therapy		99914	0	131			10.02
11.00	Speech Pathology		16580	0	0			11.00
11.01	Speech Pathology		19180	0	0			11.01
11.02	Speech Pathology		99914	0	14			11.02
12.00	Medical Social Services		16580	0	0			12.00
12.01	Medical Social Services		19180	0	0			12.01
12.02	Medical Social Services		99914	0	8			12.02
13.00	Home Health Aide		16580	0	61			13.00
13.01	Home Health Aide		19180	0	0			13.01
13.02	Home Health Aide		99914	0	293			13.02
14.00	Total (sum of lines 8-13)			0	2,637			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	14,294	0	14,294	12,770	1.119342	15.00
16.00	Cost of Drugs	9.00	433	0	433	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,365		0	366,325		1.00
2.00	Physical Therapy	0	763		0	91,529		2.00
3.00	Occupational Therapy	0	133		0	14,968		3.00
4.00	Speech Pathology	0	14		0	2,230		4.00
5.00	Medical Social Services	0	8		0	508		5.00
6.00	Home Health Aide	0	354		0	82,928		6.00
7.00	Total (sum of lines 1-6)	0	2,637		0	558,488		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1		
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	10,487	0	0	11,739	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	366,325						1.00
2.00	Physical Therapy	91,529						2.00
3.00	Occupational Therapy	14,968						3.00
4.00	Speech Pathology	2,230						4.00
5.00	Medical Social Services	508						5.00
6.00	Home Health Aide	82,928						6.00
7.00	Total (sum of lines 1-6)	558,488						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.513125	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.272196	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.455769	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167 HHA CCN: 14-7586	Period: From 10/01/2018 To 09/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2020 12:49 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	388,423
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	18,861
13.00	Total PPS Reimbursement - LUPA Episodes		0	6,907
14.00	Total PPS Reimbursement - PEP Episodes		0	1,170
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,742
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	418,103
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	418,103
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	418,103
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	418,103
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	418,103
31.01	Sequestration adjustment (see instructions)		0	8,361
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	409,742
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-0167

Period:

Worksheet H-5

HHA CCN: 14-7586

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pmHome Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		409,742	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		409,742	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		409,742	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0

Hospice CCN: 14-1616

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		17,192	17,192	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	4,894	4,894	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	162,983	49,726	212,709	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	16,056	16,056	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	59,622	0	59,622	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	9,609	9,609	-2,462	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	54,214	54,214	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	28,193	28,193	0	26.00
27.00	NURSE PRACTITIONER**	5,465	0	5,465	0	27.00
28.00	REGISTERED NURSE**	276,129	0	276,129	0	28.00
29.00	LPN/LVN**	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	96,598	0	96,598	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	13,325	13,325	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	76,540	76,540	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	600,797	269,749	870,546	-2,462	868,084

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0

Hospice CCN: 14-1616

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	17,192	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	4,894	3.00
4.00	ADMINISTRATIVE & GENERAL*	-52	212,657	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	16,056	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	59,622	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	7,147	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	54,214	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	28,193	26.00
27.00	NURSE PRACTITIONER**	0	5,465	27.00
28.00	REGISTERED NURSE**	0	276,129	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	96,598	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	13,325	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	76,540	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-52	868,032	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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

Provider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2018
To 09/30/2019Worksheet 0-1
Date/Time Prepared:
2/27/2020 12:49 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	4	4	0	4	26.00
27.00	NURSE PRACTITIONER	1	0	1	0	1	27.00
28.00	REGISTERED NURSE	44	0	44	0	44	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	15	0	15	0	15	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2	2	0	2	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	12	12	0	12	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	60	18	78	0	78	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	4	26.00
27.00	NURSE PRACTITIONER	0	1	27.00
28.00	REGISTERED NURSE	0	44	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	15	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	12	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	78	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

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

Provider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2018
To 09/30/2019Worksheet 0-2
Date/Time Prepared:
2/27/2020 12:49 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	27,951	27,951	0	27,951	26.00
27.00	NURSE PRACTITIONER	5,418	0	5,418	0	5,418	27.00
28.00	REGISTERED NURSE	273,756	0	273,756	0	273,756	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	95,769	0	95,769	0	95,769	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	13,211	13,211	0	13,211	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	75,882	75,882	0	75,882	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	374,943	117,044	491,987	0	491,987	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	27,951	26.00
27.00	NURSE PRACTITIONER	0	5,418	27.00
28.00	REGISTERED NURSE	0	273,756	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	95,769	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	13,211	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	75,882	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	491,987	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CAREProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2018
To 09/30/2019Worksheet 0-3
Date/Time Prepared:
2/27/2020 12:49 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	90	90	0	90	26.00
27.00	NURSE PRACTITIONER	17	0	17	0	17	27.00
28.00	REGISTERED NURSE	879	0	879	0	879	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	307	0	307	0	307	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42	42	0	42	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	244	244	0	244	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,203	376	1,579	0	1,579	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	90	26.00
27.00	NURSE PRACTITIONER	0	17	27.00
28.00	REGISTERED NURSE	0	879	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	307	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	244	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,579	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CAREProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2018
To 09/30/2019Worksheet 0-4
Date/Time Prepared:
2/27/2020 12:49 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	148	148	0	148	26.00
27.00	NURSE PRACTITIONER	29	0	29	0	29	27.00
28.00	REGISTERED NURSE	1,450	0	1,450	0	1,450	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	507	0	507	0	507	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	70	70	0	70	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	402	402	0	402	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,986	620	2,606	0	2,606	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	148	26.00
27.00	NURSE PRACTITIONER	0	29	27.00
28.00	REGISTERED NURSE	0	1,450	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	507	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	70	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	402	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	2,606	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 14-0167

Period:

Worksheet 0-5

Hospice CCN: 14-1616

From 10/01/2018

To 09/30/2019

Date/Time Prepared:
2/27/2020 12:49 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	24,615	24,615	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,192	13,715	30,907	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4,894	90,770	95,664	3.00
4.00	ADMINISTRATIVE & GENERAL	212,657	183,489	396,146	4.00
5.00	PLANT OPERATION & MAINTENANCE	16,056	45,953	62,009	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	16,211	16,211	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	59,622	0	59,622	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,734	1,734	10.00
11.00	MEDICAL RECORDS	0	6,964	6,964	11.00
12.00	STAFF TRANSPORTATION	7,147	0	7,147	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	54,214	0	54,214	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	78	0	78	50.00
51.00	HOSPICE ROUTINE HOME CARE	491,987	0	491,987	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,579	0	1,579	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,606	0	2,606	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	868,032	383,451	1,251,483	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	24,615	24,615					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	30,907		30,907				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	95,664	0	0		95,664		3.00
4.00	ADMINISTRATIVE & GENERAL	396,146	0	30,907	0	0	427,053	4.00
5.00	PLANT OPERATION & MAINTENANCE	62,009	0	0	0	0	62,009	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	16,211	0	0	0	0	16,211	7.00
8.00	DIETARY	0	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	59,622	0	0	0	0	59,622	9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,734	0	0	0	0	1,734	10.00
11.00	MEDICAL RECORDS	6,964	0	0	0	0	6,964	11.00
12.00	STAFF TRANSPORTATION	7,147	0	0	0	0	7,147	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	54,214	24,615	0	0	0	78,829	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0			0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	78				0	78	50.00
51.00	HOSPICE ROUTINE HOME CARE	491,987				95,664	587,651	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,579	0	0	0	0	1,579	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,606	0	0	0	0	2,606	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	0	99.00
100.00	TOTAL	1,251,483	24,615	30,907		95,664	1,251,483	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/27/2020 12:49 pm

Descriptions		ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I		
					HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	427,053					4.00
5.00	PLANT OPERATION & MAINTENANCE	32,121	94,130				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	8,397	0		24,608		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	30,884	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	898	0		0		10.00
11.00	MEDICAL RECORDS	3,607	0		0		11.00
12.00	STAFF TRANSPORTATION	3,702	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	40,833	94,130		24,608		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	40					50.00
51.00	HOSPICE ROUTINE HOME CARE	304,403					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	818	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,350	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	427,053	94,130	0	24,608	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	90,506					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	2,632				10.00
11.00	MEDICAL RECORDS	0		10,571			11.00
12.00	STAFF TRANSPORTATION	0			10,849		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	14	0	2	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	89,729	2,610	10,479	10,741	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	288	8	34	27	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	475	14	56	81	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	90,506	2,632	10,571	10,849	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 12:49 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		238,400			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	38		172	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	236,351		1,241,964	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	759	0	3,513	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1,252	0	5,834	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	238,400	0	1,251,483	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASISProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2018
To 09/30/2019Worksheet 0-6
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,628					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		28,682				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	600,797			3.00
4.00	ADMINISTRATIVE & GENERAL	0	28,682	0	-427,053	824,430	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	62,009	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	16,211	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	59,622	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	1,734	10.00
11.00	MEDICAL RECORDS	0	0	0	0	6,964	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	7,147	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	3,628	0	0	0	78,829	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	78	50.00
51.00	HOSPICE ROUTINE HOME CARE			600,797	0	587,651	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,579	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	2,606	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	24,615	30,907	95,664		427,053	100.00
101.00	UNIT COST MULTIPLIER	6.784730	1.077575	0.159228		0.517998	101.00

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

Provider CCN: 14-0167
Hospice CCN: 14-1616

Period:
From 10/01/2018
To 09/30/2019

Worksheet 0-6
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	3,628					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		3,628			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		6,284	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	3,628		3,628		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					1	50.00
51.00	HOSPICE ROUTINE HOME CARE					6,230	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	20	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	33	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	94,130	0	24,608	0	90,506	100.00
101.00	UNIT COST MULTIPLIER	25.945424	0.000000	6.782800	0.000000	14.402610	101.00

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

Provider CCN: 14-0167
Hospice CCN: 14-1616

Period:
From 10/01/2018
To 09/30/2019

Worksheet 0-6
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,284				10.00
11.00	MEDICAL RECORDS		6,284			11.00
12.00	STAFF TRANSPORTATION			33,692		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0	0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	1	1	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	6,230	6,230	33,356	0	0 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	20	20	84	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	33	33	252	0	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	2,632	10,571	10,849	0	0 100.00
101.00	UNIT COST MULTIPLIER	0.418842	1.682209	0.322005	0.000000	0.000000 101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASISProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2018
To 09/30/2019Worksheet 0-6
Part II
Date/Time Prepared:
2/27/2020 12:49 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		6,284			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	1			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	6,230			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	20	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	33	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	238,400	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	37.937619	0.000000		101.00

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

Provider CCN: 14-0167
Hospice CCN: 14-1616

Period:
From 10/01/2018
To 09/30/2019

Worksheet 0-7
Date/Time Prepared:
2/27/2020 12:49 pm

			Hospice I				
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.513125	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.455769	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.228872	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.272196	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0167

Period:

Worksheet 0-8

Hospice CCN: 14-1616

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		Hospice I		
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			172
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			1
3.00	Total average cost per diem (line 1 divided by line 2)			172.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	1	
5.00	Program cost (line 3 times line 4)	0	172	
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,241,964
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,230
8.00	Total average cost per diem (line 6 divided by line 7)			199.35
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	5,899	199	
10.00	Program cost (line 8 times line 9)	1,175,966	39,671	
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			3,513
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			20
13.00	Total average cost per diem (line 11 divided by line 12)			175.65
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	20	0	
15.00	Program cost (line 13 times line 14)	3,513	0	
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			5,834
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			33
18.00	Total average cost per diem (line 16 divided by line 17)			176.79
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	30	0	
20.00	Program cost (line 18 times line 19)	5,304	0	
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,251,483
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			6,284
23.00	Average cost per diem (line 21 divided by line 22)			199.15

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/27/2020 12:49 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		130,163	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		2.75	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		130,163	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3424

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		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	129,337	0	129,337	0	129,337
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	235,306	0	235,306	0	235,306
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	47,182	0	47,182	0	47,182
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	411,825	0	411,825	0	411,825
11.00 Physician Services Under Agreement	0	0	0	0	0
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	0	0	0	0
14.00 Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00 Medical Supplies	0	21,365	21,365	0	21,365
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	105	105	0	105
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	21,470	21,470	0	21,470
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	411,825	21,470	433,295	0	433,295
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	0	0	0	0
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD					
29.00 Facility Costs	0	21,436	21,436	0	21,436
30.00 Administrative Costs	49,084	41,836	90,920	0	90,920
31.00 Total Facility Overhead (sum of lines 29 and 30)	49,084	63,272	112,356	0	112,356
32.00 Total facility costs (sum of lines 22, 28 and 31)	460,909	84,742	545,651	0	545,651

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3424

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	514	129,851	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	235,306	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	47,182	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	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)	514	412,339	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	21,365	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	105	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,470	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	514	433,809	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-105	21,331	29.00
30.00	Administrative Costs	-7,335	83,585	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-7,440	104,916	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,926	538,725	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3425

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	86,224	0	86,224	0	86,224	1.00
2.00	Physician Assistant	0	27,420	27,420	0	27,420	2.00
3.00	Nurse Practitioner	135,872	0	135,872	0	135,872	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	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)	222,096	27,420	249,516	0	249,516	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	13,824	13,824	0	13,824	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	17,182	17,182	0	17,182	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,006	31,006	0	31,006	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	222,096	58,426	280,522	0	280,522	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	0	0	0	0	0	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	19,733	19,733	0	19,733	29.00
30.00	Administrative Costs	33,930	82,517	116,447	0	116,447	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,930	102,250	136,180	0	136,180	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	256,026	160,676	416,702	0	416,702	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3425

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	313	86,537		1.00
2.00	Physician Assistant	0	27,420		2.00
3.00	Nurse Practitioner	0	135,872		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		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)	313	249,829		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	13,824		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	17,182		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,006		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	313	280,835		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	-17,182	2,551		29.00
30.00	Administrative Costs	-51,856	64,591		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-69,038	67,142		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-68,725	347,977		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 15-3979

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	350,098	0	350,098	0	350,098	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	180,631	0	180,631	0	180,631	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	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)	530,729	0	530,729	0	530,729	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	61,723	61,723	0	61,723	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	8,589	8,589	0	8,589	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	70,312	70,312	0	70,312	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	530,729	70,312	601,041	0	601,041	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	33,229	33,229	0	33,229	29.00
30.00	Administrative Costs	167,610	144,687	312,297	0	312,297	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	167,610	177,916	345,526	0	345,526	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	698,339	248,228	946,567	0	946,567	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 15-3979

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	257	350,355	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	180,631	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	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)	257	530,986	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	61,723	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	8,589	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	70,312	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	257	601,298	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	-8,589	24,640	29.00
30.00	Administrative Costs	-65,525	246,772	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-74,114	271,412	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-73,857	872,710	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-8551

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	602,106	0	602,106	0	602,106	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	305,589	0	305,589	0	305,589	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	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)	907,695	0	907,695	0	907,695	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	27,109	27,109	0	27,109	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	13,341	13,341	0	13,341	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,450	40,450	0	40,450	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	907,695	40,450	948,145	0	948,145	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	5,331	5,331	0	5,331	29.00
30.00	Administrative Costs	104,870	195,981	300,851	0	300,851	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	104,870	201,312	306,182	0	306,182	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,012,565	241,762	1,254,327	0	1,254,327	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-8551

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

RHC IV

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-196,345	405,761	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	49,908	355,497	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	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)	-146,437	761,258	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	27,109	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	13,341	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,450	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-146,437	801,708	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	-13,341	-8,010	29.00
30.00	Administrative Costs	-90,389	210,462	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-103,730	202,452	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-250,167	1,004,160	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-3424

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				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	0.53	1,693	4,200	2,226		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.47	3,192	2,100	3,087		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.00	4,885		5,313	5,313	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.00	4,885			5,313	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)					433,809	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)					433,809	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)					104,916	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					233,689	15.00
16.00	Total overhead (sum of lines 14 and 15)					338,605	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					338,605	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					338,605	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					772,414	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-3425

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.35	1,477	4,200	1,470		1.00
2.00	Physician Assistant	0.11	101	2,100	231		2.00
3.00	Nurse Practitioner	0.57	713	2,100	1,197		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.03	2,291		2,898	2,898	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.03	2,291			2,898	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)					280,835	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)					280,835	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)					67,142	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					187,636	15.00
16.00	Total overhead (sum of lines 14 and 15)					254,778	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					254,778	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					254,778	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					535,613	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 15-3979

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.67	3,768	4,200	2,814		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.95	2,641	2,100	1,995		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.62	6,409		4,809	6,409	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.62	6,409			6,409	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)					601,298	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)					601,298	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)					271,412	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					377,419	15.00
16.00	Total overhead (sum of lines 14 and 15)					648,831	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					648,831	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					648,831	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,250,129	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-8551

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 12:49 pm

				RHC IV		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	1.34	3,903	4,200	5,628		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.37	2,631	2,100	2,877		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.71	6,534		8,505	8,505	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.71	6,534			8,505	8.00
9.00	Physician Services Under Agreements		45			45	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)					801,708	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)					801,708	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)					202,452	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					405,248	15.00
16.00	Total overhead (sum of lines 14 and 15)					607,700	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					607,700	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					607,700	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,409,408	20.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 14-3424		Date/Time Prepared: 2/27/2020 12:49 pm	
		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)			772,414	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			20,342	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			752,072	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,313	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)			5,313	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			141.55	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)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		141.55	141.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		415	1,244	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		58,743	176,088	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	234,831	16.00
16.01	Total program charges (see instructions)(from contractor's records)			209,140	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			4,482	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			5,033	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.)			161,264	16.04
16.05	Total program cost (see instructions)		0	166,297	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			28,218	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			35,288	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			166,297	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			12,216	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			178,513	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)			178,513	26.00
26.01	Sequestration adjustment (see instructions)			3,570	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			185,155	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)			-10,212	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167 Component CCN: 14-3425	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 12:49 pm		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			535,613	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			19,453	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			516,160	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,898	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)			2,898	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			178.11	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)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			178.11	178.11	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			230	691	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			40,965	123,074	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	164,039	16.00
16.01	Total program charges (see instructions)(from contractor's records)				113,726	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				3,049	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				4,398	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.)				113,112	16.04
16.05	Total program cost (see instructions)			0	117,510	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				18,251	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				18,485	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				117,510	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				11,123	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				128,633	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)				128,633	26.00
26.01	Sequestration adjustment (see instructions)				2,573	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				106,322	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)				19,738	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 12:49 pm		
			Title XVIII	RHC III	Cost	
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,250,129	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			29,344	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,220,785	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,409	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)			6,409	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			190.48	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)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			190.48	190.48	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			767	2,302	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			146,098	438,485	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	584,583	16.00
16.01	Total program charges (see instructions)(from contractor's records)				407,961	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				5,811	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				8,327	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.)				417,506	16.04
16.05	Total program cost (see instructions)			0	425,833	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				54,374	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				69,555	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				425,833	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				16,580	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				442,413	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)				442,413	26.00
26.01	Sequestration adjustment (see instructions)				8,848	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				382,350	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)				51,215	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	RHC IV	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)			1,409,408	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			29,674	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,379,734	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,505	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			45	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,550	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			161.37	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)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		161.37	161.37	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		482	1,446	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		77,780	233,341	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	311,121	16.00
16.01	Total program charges (see instructions)(from contractor's records)			222,089	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			15,083	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			21,129	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.)			211,583	16.04
16.05	Total program cost (see instructions)		0	232,712	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			25,513	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			36,299	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			232,712	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			16,962	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			249,674	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)			249,674	26.00
26.01	Sequestration adjustment (see instructions)			4,993	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			257,976	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)			-13,295	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: 14-0167 Component CCN: 14-3424	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 12:49 pm	
		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)		412,339	412,339	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000962	0.004768	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		397	1,966	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,411	5,651	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,808	7,617	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		433,809	433,809	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		338,605	338,605	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008778	0.017558	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,972	5,945	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		6,780	13,562	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		24	119	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		282.50	113.97	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		15	70	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,238	7,978	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)			20,342	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)			12,216	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 14-3425	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		249,829	249,829	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001245	0.009259	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		311	2,313	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,002	5,574	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,313	7,887	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		280,835	280,835	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		254,778	254,778	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008236	0.028084	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,098	7,155	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		4,411	15,042	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		16	119	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		275.69	126.40	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		11	64	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		3,033	8,090	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)			19,453	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)			11,123	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		530,986	530,986	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001187	0.007171	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		630	3,808	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,841	6,835	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,471	10,643	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		601,298	601,298	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		648,831	648,831	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005773	0.017700	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,746	11,484	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		7,217	22,127	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		24	145	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		300.71	152.60	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		12	85	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		3,609	12,971	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)			29,344	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)			16,580	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 12:49 pm	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		761,258	761,258	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001656	0.003637	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,261	2,769	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,008	5,841	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,269	8,610	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		801,708	801,708	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		607,700	607,700	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010314	0.010740	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		6,268	6,527	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		14,537	15,137	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		56	123	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		259.59	123.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		35	64	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		9,086	7,876	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)			29,674	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)			16,962	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-3424	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 12:49 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		185,155	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)		185,155	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,212	6.02
7.00	Total Medicare program liability (see instructions)		174,943	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-3425	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 12:49 pm
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		106,322	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)		106,322	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		19,738	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		126,060	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 12:49 pm
		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		382,350	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)		382,350	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		51,215	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		433,565	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 12:49 pm
		RHC IV	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		257,976	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)		257,976	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		13,295	6.02
7.00	Total Medicare program liability (see instructions)		244,681	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00