

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: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 12/30/2020 1:42 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 12/30/2020	Time: 1:42 pm
	2. ☐ Manually prepared 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 BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ 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) TIMOTHY MOORE

Officer or Administrator of Provider(s)

CFO/VP-FINANCE

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	-1,133,684	-261,452	0	0	1.00
2.00	Subprovider - IPF	0	62,849	-20		0	2.00
3.00	Subprovider - IRF	0	103,120	-370		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	37,094	-20,616		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		17,231		0	10.00
200.00	Total	0	-930,621	-265,227	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: 14-0015		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 12/30/2020 1:42 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1005 BROADWAY			PO Box:				1.00		
2.00	City: QUINCY			State: IL		Zip Code: 62301		County: ADAMS		
		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		BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O
4.00	Subprovider - IPF		BLESSING PSYCHIATRIC UNIT	14S015	99914	4	10/01/1993	N	P	O
5.00	Subprovider - IRF		BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984			
15.00	Hospital-Based Health Clinic - RHC		GOLDEN CLINIC	143422	99914		09/08/1996	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)						10/01/2019		09/30/2020	
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			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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.			1,561	3,899	0	1,755	6,026	107	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0015

Period:
From 10/01/2019
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	121	152	0	0	266		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.					10/01/2019	09/30/2020	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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 in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
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.					N		
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		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					Y		
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					20.00	1	

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1		60.02	
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1		60.03	
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.03	1		60.04	
60.05	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.04	1		60.05	
60.06	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.05	1		60.06	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			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)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			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)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 12/30/2020 1:42 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			Y			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:			128,184	3,273,930		0118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 12/30/2020 1:42 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H132		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: BLESSING CROPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131		141.00	
142.00	Street: BROADWAY AT 11TH STREET	PO Box:				142.00	
143.00	City: QUINCY	State: IL		Zip Code: 62301		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.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						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	
		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 12/30/2020 1:42 pm
			Beginning 1.00	Ending 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 12/30/2020 1:42 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 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?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		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 1.00	Date 2.00	Y/N 3.00 Date 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	10/31/2020	Y 10/31/2020
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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
12/30/2020 1:42 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		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.	CONNIE	ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALT H.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0015

Period:
From 10/01/2019
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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.	REIMBURSEMENT COORDINATOR		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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	264	92,852	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)		264	92,852	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,856	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		280	98,708	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	3,772		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,320		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	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		318				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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	22,668	1,347	47,897			1.00
2.00	HMO and other (see instructions)	5,363	11,680				2.00
3.00	HMO IPF Subprovider	32	0				3.00
4.00	HMO IRF Subprovider	434	418				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)	22,668	1,347	47,897			7.00
8.00	INTENSIVE CARE UNIT	2,546	156	5,453			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		58	1,903			13.00
14.00	Total (see instructions)	25,214	1,561	55,253	16.57	2,147.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	314	0	3,062	0.03	22.45	16.00
17.00	SUBPROVIDER - IRF	2,942	121	4,622	0.40	25.44	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,582	0	5,322	0.00	27.79	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	23,102	0	41,824	0.00	42.27	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	21.60	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,483	0	5,358	0.00	8.12	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.00	2,295.22	27.00
28.00	Observation Bed Days		0	5,579			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			792			30.00
31.00	Employee discount days - IRF			91			31.00
32.00	Labor & delivery days (see instructions)	0	107	393			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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

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	5,550	666	12,389	1.00
2.00 HMO and other (see instructions)			1,062	1,866		2.00
3.00 HMO IPF Subprovider				184		3.00
4.00 HMO IRF Subprovider				17		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	5,550	666	12,389	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	40	99	500	16.00
17.00 SUBPROVIDER - IRF	0.00	0	201	11	311	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 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
12/30/2020 1:42 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	146,599,670	0	146,599,670	4,762,166.83	30.78
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		243,100	0	243,100	1,328.00	183.06
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		12,300,669	0	12,300,669	71,695.40	171.57
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		46,580,997	0	46,580,997	16,392.75	2,841.56
7.00	Interns & residents (in an approved program)	21.00	1,098,535	0	1,098,535	37,683.06	29.15
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	1,596,108	-28,980	1,567,128	56,878.65	27.55
10.00	Excluded area salaries (see instructions)		13,039,837	2,123,075	15,162,912	408,835.20	37.09
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,875,666	0	1,875,666	24,394.55	76.89
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		526,539	0	526,539	3,433.00	153.38
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		5,820,159	0	5,820,159	68,639.83	84.79
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		39,533,369	0	39,533,369		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		16,730,040	0	16,730,040		
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		38,358	0	38,358		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,967,013	0	1,967,013		
24.00	Wage-related costs (RHC/FQHC)		156,752	0	156,752		
25.00	Interns & residents (in an approved program)		363,872	0	363,872		
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		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
12/30/2020 1:42 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	3,256,594	0	3,256,594	197,310.54	16.50	26.00
27.00	Administrative & General	5.00	26,044,284	-78,381	25,965,903	856,950.92	30.30	27.00
28.00	Administrative & General under contract (see inst.)		821,917	0	821,917	3,494.37	235.21	28.00
29.00	Maintenance & Repairs	6.00	3,163,340	0	3,163,340	133,743.97	23.65	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	41,646	0	41,646	2,555.78	16.29	31.00
32.00	Housekeeping	9.00	2,901,671	0	2,901,671	188,231.61	15.42	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,821,010	-1,791,623	1,029,387	67,574.76	15.23	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,791,623	1,791,623	117,612.30	15.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	8,889,359	-112,270	8,777,089	255,745.81	34.32	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	3,737,881	0	3,737,881	162,760.05	22.97	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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
12/30/2020 1:42 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)	87,441,386	0	87,441,386	4,639,889.99	18.85	1.00
2.00	Excluded area salaries (see instructions)	14,635,945	2,094,095	16,730,040	465,713.85	35.92	2.00
3.00	Subtotal salaries (line 1 minus line 2)	72,805,441	-2,094,095	70,711,346	4,174,176.14	16.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,222,364	0	8,222,364	96,467.38	85.23	4.00
5.00	Subtotal wage-related costs (see inst.)	39,571,727	0	39,571,727	0.00	55.96	5.00
6.00	Total (sum of lines 3 thru 5)	120,599,532	-2,094,095	118,505,437	4,270,643.52	27.75	6.00
7.00	Total overhead cost (see instructions)	51,677,702	-190,651	51,487,051	1,985,980.11	25.93	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 12/30/2020 1:42 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		5,977,621	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)		1,562,018	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		27,141,259	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		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		107,588	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)		324,724	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		135,471	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		10,149,640	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		181,120	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		1,370,126	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		46,949,567	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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part V
Date/Time Prepared:
12/30/2020 1:42 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	2,024,767	46,949,567	1.00
2.00	Hospital	1,875,666	39,533,369	2.00
3.00	Subprovider - IPF	0	326,162	3.00
4.00	Subprovider - IRF	8,237	481,138	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	140,864	458,073	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	909,117	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	427,037	13.00
14.00	Hospital-Based Health Clinic RHC	0	156,752	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	4,657,919	18.00

Health Financial Systems		BLESSING HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0015 Component CCN: 14-7031		Period: From 10/01/2019 To 09/30/2020	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 12/30/2020 1:42 pm	
						PPS	
				1.00			
0.00 County				ADAMS		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	6,093	0	4,271	10,364	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	866.00	0.00	1,045.00	1,911.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.99	0.00	0.99	4.00
5.00	Other Administrative Personnel			9.45	0.00	9.45	5.00
6.00	Direct Nursing Service			16.59	0.00	16.59	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			10.61	0.00	10.61	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.59	0.00	1.59	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.36	0.00	0.36	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.95	0.00	0.95	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			4.98	0.00	4.98	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).	99914					20.00
20.01		99916					20.01
20.02		99926					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	9,958	337	189	112	10,596	21.00
22.00	Skilled Nursing Visit Charges	1,691,804	57,290	32,082	19,040	1,800,216	22.00
23.00	Physical Therapy Visits	6,938	232	76	87	7,333	23.00
24.00	Physical Therapy Visit Charges	1,178,108	39,440	12,904	14,790	1,245,242	24.00
25.00	Occupational Therapy Visits	1,824	203	18	22	2,067	25.00
26.00	Occupational Therapy Visit Charges	309,912	34,510	3,044	3,740	351,206	26.00
27.00	Speech Pathology Visits	87	33	0	0	120	27.00
28.00	Speech Pathology Visit Charges	14,790	5,610	0	0	20,400	28.00
29.00	Medical Social Service Visits	23	2	0	1	26	29.00
30.00	Medical Social Service Visit Charges	3,910	340	0	170	4,420	30.00
31.00	Home Health Aide Visits	2,550	379	2	29	2,960	31.00
32.00	Home Health Aide Visit Charges	239,516	35,626	188	2,726	278,056	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	21,380	1,186	285	251	23,102	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)	3,438,040	172,816	48,218	40,466	3,699,540	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,714		137	21	1,872	36.00
37.00	Total Number of Outlier Episodes		37		0	37	37.00
38.00	Total Non-Routine Medical Supply Charges	98,636	5,663	7,333	121	111,753	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0015

Period:

Worksheet S-8

Component CCN: 14-3422

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 pm

				RHC I		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			102 PRAIRIE MILLS ROAD			1.00
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			GOLDEN IL 62339		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			08:00		17:00 08:00 11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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			ADAMS		2.00	
			Tuesday		Wednesday		Thursday
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00 08:00 17:00 08:00 17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0015

Period:

Worksheet S-8

Component CCN: 14-3422

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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	08:00	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0015

Period:

Worksheet S-9

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020PARTS I THROUGH IV
Date/Time Prepared:
12/30/2020 1:42 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	0	0	0	10.00
11.00	Hospice Routine Home Care	19,531	553	869	20,953	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	436	45	66	547	13.00
14.00	Total Hospice Days	19,967	598	935	21,500	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	436	45	66	547	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet S-10

Date/Time Prepared:
12/30/2020 1:42 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)		0.186785		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		26,878,817		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		22,247,686		5.00
6.00	Medicaid charges		259,862,389		6.00
7.00	Medicaid cost (line 1 times line 6)		48,538,396		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)		0		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)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	20,031,163	10,655,361	30,686,524	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,741,521	10,655,361	14,396,882	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,741,521	10,655,361	14,396,882	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		19,425,685		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,432,418		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,203,720		27.01
28.00	Non-Medicare bad debt expense (see instructions)		17,221,965		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,988,107		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		18,384,989		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		18,384,989		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
12/30/2020 1:42 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	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	660	660	34,813	35,473	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	6,056,511	6,056,511	14,444	6,070,955	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1,758,880	1,758,880	1,539,502	3,298,382	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	0	0	69,918	69,918	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,474,321	12,474,321	32,924	12,507,245	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,256,594	48,171,380	51,427,974	51,427,974	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,044,284	124,475,804	150,520,088	150,231,240	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,163,340	6,289,807	9,453,147	9,453,147	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,646	1,675,231	1,716,877	1,716,877	8.00
9.00	00900	HOUSEKEEPING	2,901,671	2,340,745	5,242,416	5,402,143	9.00
10.00	01000	DIETARY	2,821,010	4,224,411	7,045,421	2,570,875	10.00
11.00	01100	CAFETERIA	0	0	4,474,546	4,474,546	11.00
13.00	01300	NURSING ADMINISTRATION	8,889,359	735,462	9,624,821	9,512,531	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,737,881	1,123,813	4,861,694	4,861,694	16.00
20.00	02000	NURSING SCHOOL	4,043,675	3,327,133	7,370,808	7,867,402	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,098,535	0	1,098,535	1,098,535	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,153,264	2,153,264	2,153,264	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	301,982	7,296	309,278	309,278	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	58,951	729	59,680	74,512	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	298,376	-606	297,770	297,770	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	187,700	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	228,322	23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,357,499	3,538,223	29,895,722	-1,639,033	30.00
31.00	03100	INTENSIVE CARE UNIT	4,722,026	570,528	5,292,554	-231,331	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	1,142,032	40.00
41.00	04100	SUBPROVIDER - IRF	1,662,521	149,369	1,811,890	-18,320	41.00
43.00	04300	NURSERY	309,313	62,470	371,783	-69,322	43.00
44.00	04400	SKILLED NURSING FACILITY	1,596,108	249,086	1,845,194	-31,183	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,860,640	23,264,395	34,125,035	-17,483,734	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	687,394	280,607	968,001	-149,931	52.00
53.00	05300	ANESTHESIOLOGY	181,162	811,933	993,095	-309,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,953,544	1,872,502	6,826,046	-214,608	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,188,734	542,620	1,731,354	-7,099	55.00
57.00	05700	CT SCAN	610,477	290,314	900,791	-53,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	367,525	468,870	836,395	-203	58.00
60.00	06000	LABORATORY	3,212,612	5,417,434	8,630,046	-55,892	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	168,208	1,204,202	1,372,410	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,296,264	651,827	2,948,091	-315,526	65.00
66.00	06600	PHYSICAL THERAPY	1,474,801	18,209	1,493,010	-1,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	883,254	3,378	886,632	-609	67.00
68.00	06800	SPEECH PATHOLOGY	285,504	6,702	292,206	-1,530	68.00
69.00	06900	ELECTROCARDIOLOGY	2,202,502	8,975,553	11,178,055	-8,185,597	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	499,814	105,782	605,596	4,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	920,590	1,019,768	1,940,358	10,687,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,355,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,842,307	22,399,619	27,241,926	-183	73.00
74.00	07400	RENAL DIALYSIS	0	970,953	970,953	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	689,135	306,506	995,641	10,056	88.00
90.00	09000	CLINIC	494,297	85,468	579,765	-101	90.00
90.01	09001	OUTPATIENT INFUSION	466,512	84,086	550,598	-2,822	90.01
91.00	09100	EMERGENCY	11,335,291	2,151,737	13,487,028	-201,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,110,211	924,898	4,035,109	-2,719	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	1,618,285	1,618,285	-1,618,285	113.00
116.00	11600	HOSPICE	1,448,658	616,129	2,064,787	9,715	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,484,207	293,476,294	437,960,501	-6,708	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,887,778	75,957	1,963,735	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	193.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
12/30/2020 1:42 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	
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	6,708	6,708	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	227,685	696,234	923,919	0	923,919	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	146,599,670	294,248,485	440,848,155	0	440,848,155	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
12/30/2020 1:42 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	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	2,416	37,889	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	-5,694,141	376,814	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	3,697,879	6,996,261	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	-60,064	9,854	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	836,783	836,783	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	122,127	122,127	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,196,026	15,703,271	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-37,805,608	13,622,366	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-90,518,440	59,712,800	5.00
6.00	00600	MAINTENANCE & REPAIRS	-1,055,692	8,397,455	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-15,203	1,701,674	8.00
9.00	00900	HOUSEKEEPING	-791,527	4,610,616	9.00
10.00	01000	DIETARY	-844,157	1,726,718	10.00
11.00	01100	CAFETERIA	-1,488,556	2,985,990	11.00
13.00	01300	NURSING ADMINISTRATION	1,183,852	10,696,383	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,153,448	6,015,142	16.00
20.00	02000	NURSING SCHOOL	-4,802,358	3,065,044	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,098,535	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,153,264	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-70,283	238,995	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-55,300	19,212	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	297,770	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	-67,520	120,180	23.04
23.05	02305	PARAMED ED PRGM-HIM	-63,818	164,504	23.05
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,629,160	24,627,529	30.00
31.00	03100	INTENSIVE CARE UNIT	-557,322	4,503,901	31.00
40.00	04000	SUBPROVIDER - IPF	-1,053	1,140,979	40.00
41.00	04100	SUBPROVIDER - IRF	-8,669	1,784,901	41.00
43.00	04300	NURSERY	0	302,461	43.00
44.00	04400	SKILLED NURSING FACILITY	-435	1,813,576	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,224,600	15,416,701	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	818,070	52.00
53.00	05300	ANESTHESIOLOGY	0	683,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,382,826	5,228,612	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,724,255	55.00
57.00	05700	CT SCAN	0	847,660	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	836,192	58.00
60.00	06000	LABORATORY	-77,328	8,496,826	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,372,410	62.00
65.00	06500	RESPIRATORY THERAPY	-7,973	2,624,592	65.00
66.00	06600	PHYSICAL THERAPY	0	1,491,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	886,023	67.00
68.00	06800	SPEECH PATHOLOGY	0	290,676	68.00
69.00	06900	ELECTROCARDIOLOGY	-9,250	2,983,208	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-70,448	539,635	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,817	12,650,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,355,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,352,098	24,889,645	73.00
74.00	07400	RENAL DIALYSIS	0	970,953	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-56,790	948,907	88.00
90.00	09000	CLINIC	0	579,664	90.00
90.01	09001	OUTPATIENT INFUSION	0	547,776	90.01
91.00	09100	EMERGENCY	-6,745,651	6,539,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-7,777	4,024,613	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	170,185	2,244,687	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-149,078,514	288,875,279	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,963,735	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	6,708	193.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.04	19304	RENTED SPACE	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	923,919	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-149,078,514	291,769,641	200.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
12/30/2020 1:42 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,791,623	2,682,923		1.00
	0		1,791,623	2,682,923		
	B - RECLASS C-SECTION COSTS					
1.00	OPERATING ROOM	50.00	11,575	0		1.00
	0		11,575	0		
	C - RECLASS COSTS WHILE UNITS EXCLUDED					
1.00	SUBPROVIDER - IPF	40.00	1,128,354	26,824		1.00
	TOTALS		1,128,354	26,824		
	D - RECLASS CAPITAL RELATED INSURANCE					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	34,813		1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	66,867		2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	96,585		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,637		4.00
	0		0	220,902		
	E - RECLASS VOLUNTEER SERVICES					
1.00	HOSPICE	116.00	14,226	2,284		1.00
	0		14,226	2,284		
	F - RECLASS HEALTH EDUCATION					
1.00	HEALTH EDUCATION	193.03	6,688	20		1.00
	0		6,688	20		
	G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1,442,917		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,287		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	165,081		3.00
	0		0	1,618,285		
	H - RECLASS SUMMER LAB SCHOOL WAGES					
1.00	PARAMED ED PRGM-LABORATORY	23.02	14,832	0		1.00
	TOTALS		14,832	0		
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,687,759		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,355,503		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	0		0	27,043,262		
	J - RECLASS PRECEPTOR PAY					
1.00	NURSING SCHOOL	20.00	940,576	0		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

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
12/30/2020 1:42 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
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
0		940,576	0		
K - RECLASS RENT EXPENSE					
1.00	CAP REL COSTS-MOB PHASE I	1.04	0	69,918	1.00
2.00		0.00	0	0	2.00
0			0	69,918	
L - RECLASS LEASEHOLD IMP DEPR					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	16,774	1.00
2.00	RESPIRATORY THERAPY	65.00	0	12,491	2.00
3.00	LABORATORY	60.00	0	11,913	3.00
4.00	RURAL HEALTH CLINIC	88.00	0	11,245	4.00
0			0	52,423	
M - RECLASS OTHER PARAMEDIC PROGRAMS					
1.00	PARAMED ED PRGM-RESPIRATORY	23.04	159,258	28,442	1.00
2.00	PARAMED ED PRGM-HIM	23.05	150,035	78,287	2.00
0			309,293	106,729	
N - RECLASS CONTRACTED HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	159,727	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	159,727	
500.00	Grand Total: Increases		4,217,167	31,983,297	500.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
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	Decreases						12/30/2020 1:42 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,791,623	2,682,923	0		1.00
	0		1,791,623	2,682,923			
	B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	11,575	0	0		1.00
	0		11,575	0			
	C - RECLASS COSTS WHILE UNITS EXCLUDED						
1.00	ADULTS & PEDIATRICS	30.00	1,128,354	26,824	0		1.00
	TOTALS		1,128,354	26,824			
	D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	220,902	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	0		0	220,902			
	E - RECLASS VOLUNTEER SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	14,226	2,284	0		1.00
	0		14,226	2,284			
	F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	6,688	20	0		1.00
	0		6,688	20			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,618,285	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	0		0	1,618,285			
	H - RECLASS SUMMER LAB SCHOOL WAGES						
1.00	NURSING SCHOOL	20.00	14,832	0	0		1.00
	TOTALS		14,832	0			
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	26,827	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	167,800	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	637	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	1,837	0		4.00
5.00	NURSERY	43.00	0	28,125	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	2,203	0		6.00
7.00	OPERATING ROOM	50.00	0	17,392,053	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	119,342	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	309,260	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	214,608	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,099	0		11.00
12.00	CT SCAN	57.00	0	53,131	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	203	0		13.00
14.00	LABORATORY	60.00	0	67,805	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	321,292	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	1,703	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	609	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	1,530	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	8,185,597	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,910	0		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	183	0		21.00
22.00	RURAL HEALTH CLINIC	88.00	0	1,189	0		22.00
23.00	CLINIC	90.00	0	101	0		23.00
24.00	OUTPATIENT INFUSION	90.01	0	2,822	0		24.00
25.00	EMERGENCY	91.00	0	127,814	0		25.00
26.00	HOME HEALTH AGENCY	101.00	0	2,719	0		26.00
27.00	HOSPICE	116.00	0	4,863	0		27.00
	0		0	27,043,262			
	J - RECLASS PRECEPTOR PAY						
1.00	NURSING ADMINISTRATION	13.00	105,582	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	457,028	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	63,531	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	12,509	0	0		4.00
5.00	SUBPROVIDER - IRF	41.00	16,483	0	0		5.00
6.00	NURSERY	43.00	41,197	0	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	28,980	0	0		7.00
8.00	OPERATING ROOM	50.00	103,256	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	19,014	0	0		9.00
10.00	RESPIRATORY THERAPY	65.00	6,725	0	0		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	10,377	0	0		11.00
12.00	EMERGENCY	91.00	73,962	0	0		12.00
13.00	HOSPICE	116.00	1,932	0	0		13.00
	0		940,576	0			

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
12/30/2020 1:42 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - RECLASS RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69,918	10		1.00
2.00		0.00	0	0	10		2.00
	0		0	69,918			
	L - RECLASS LEASEHOLD IMP DEPR						
1.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	52,423	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	52,423			
	M - RECLASS OTHER PARAMEDIC PROGRAMS						
1.00	ADMINISTRATIVE & GENERAL	5.00	64,155	0	0		1.00
2.00	NURSING SCHOOL	20.00	245,138	106,729	0		2.00
	0		309,293	106,729			
	N - RECLASS CONTRACTED HOUSEKEEPING						
1.00	NURSING SCHOOL	20.00	0	77,283	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	82,114	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	330	0		3.00
	0		0	159,727			
500.00	Grand Total: Decreases		4,217,167	31,983,297			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	14,717,941	1,411,988	0	1,411,988	0	1.00
2.00	Land Improvements	8,120,095	1,965,302	0	1,965,302	248,016	2.00
3.00	Buildings and Fixtures	140,352,698	12,129,434	0	12,129,434	951,424	3.00
4.00	Building Improvements	3,531,182	0	0	0	0	4.00
5.00	Fixed Equipment	79,839,305	21,810,839	0	21,810,839	194,708	5.00
6.00	Movable Equipment	181,284,263	27,729,979	0	27,729,979	2,398,599	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	427,845,484	65,047,542	0	65,047,542	3,792,747	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	427,845,484	65,047,542	0	65,047,542	3,792,747	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	16,129,929	0				1.00
2.00	Land Improvements	9,837,381	0				2.00
3.00	Buildings and Fixtures	151,530,708	0				3.00
4.00	Building Improvements	3,531,182	0				4.00
5.00	Fixed Equipment	101,455,436	0				5.00
6.00	Movable Equipment	206,615,643	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	489,100,279	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	489,100,279	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
12/30/2020 1:42 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
1.01	CAP REL COSTS-BUTLER BUILDING	660	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	6,056,511	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1,758,880	0	0	0	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	12,474,321	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	20,290,372	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
1.01	CAP REL COSTS-BUTLER BUILDING	0	660				1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	6,056,511				1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1,758,880				1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0				1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0				1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0				1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,474,321				2.00
3.00	Total (sum of lines 1-2)	0	20,290,372				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
12/30/2020 1:42 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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	41,946	0	41,946	0.000091	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	208,474,104	0	208,474,104	0.450138	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	48,001,275	0	48,001,275	0.103645	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0.000000	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	206,615,643	0	206,615,643	0.446126	0	2.00
3.00	Total (sum of lines 1-2)	463,132,968	0	463,132,968	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	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	3,076	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	0	309,947	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	6,899,675	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	9,854	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	753,690	83,093	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	122,127	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	15,680,575	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	23,769,090	92,947	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	34,813	0	0	37,889	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	66,867	0	0	376,814	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1	96,585	0	0	6,996,261	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	9,854	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	836,783	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	122,127	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	59	22,637	0	0	15,703,271	2.00
3.00	Total (sum of lines 1-2)	60	220,902	0	0	24,082,999	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
12/30/2020 1:42 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
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			0CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BLDG & FIXTURES (chapter 2)			0CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BLDG & FIXTURES (chapter 2)			0CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			0CAP REL COSTS-MOB PHASE I	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-OAK STREET MALL (chapter 2)			0CAP REL COSTS-OAK STREET MALL	1.05	0	1.05
1.06	Investment income - CAP REL COSTS-BRCN AT 36TH ST (chapter 2)			0CAP REL COSTS-BRCN AT 36TH ST	1.06	0	1.06
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)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-236,592	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,030	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-28,101,160			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	-21,278,525			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,488,556	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	A	-2,070,536	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-71,976	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-718,292	NURSING SCHOOL	20.00	0	19.00
20.00	Vending machines	B	-23,918	DIETARY	10.00	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
12/30/2020 1:42 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	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING			0CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BLDG & FIXTURES			0CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BLDG & FIXTURES			0CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-MOB PHASE I			0CAP REL COSTS-MOB PHASE I	1.04	0	26.04
26.05	Depreciation - CAP REL COSTS-OAK STREET MALL			0CAP REL COSTS-OAK STREET MALL	1.05	0	26.05
26.06	Depreciation - CAP REL COSTS-BRCN AT 36TH ST			0CAP REL COSTS-BRCN AT 36TH ST	1.06	0	26.06
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP 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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	RENTAL INSURANCE EXPENSE	A	-14,010	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	DAMAGED GOODS	B	105,246	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CHILD CARE CENTER	B	-1,975,829	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	BOOKKEEPING FEES	B	-147,809	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RADIOLOGY TUITION	B	-70,283	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.04
33.05	PRINT SHOP	B	-83,603	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HEALTH PROMOTIONS	B	-119,265	NURSING ADMINISTRATION	13.00	0	33.06
33.07	HOUSEKEEPING SERVICES	B	-618,362	HOUSEKEEPING	9.00	0	33.07
33.08	ADVERTISING	A	-156	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	ADVERTISING	A	-1,489,407	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING	A	-1,934	DIETARY	10.00	0	33.10
33.11	ADVERTISING	A	-82,405	NURSING SCHOOL	20.00	0	33.11
33.12	ADVERTISING	A	-310	SUBPROVIDER - IPF	40.00	0	33.12
33.13	ADVERTISING	A	-920	LABORATORY	60.00	0	33.13
33.14	ADVERTISING	A	-115	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	ADVERTISING	A	-7,119	HOME HEALTH AGENCY	101.00	0	33.15
33.16	RENTAL PROPERTY EXPENSE	A	-94,055	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.16
33.17	REAL ESTATE TAXES ON RENTAL	A	-202,721	MAINTENANCE & REPAIRS	6.00	0	33.17
33.18	RENTAL PROPERTY EXPENSE	A	-30,784	MAINTENANCE & REPAIRS	6.00	0	33.18
33.19	INTEREST INCOME	A	-1,442,916	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11	33.19
33.20	INTEREST INCOME	A	-10,228	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.20
33.21	INTEREST INCOME	A	-165,081	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	DIETARY OUTSIDE SERVICES-SALARIES	A	-48,222	DIETARY	10.00	0	33.22
33.23	DIETARY OUTSIDE SERVICES-BENEFITS	A	-15,469	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	PHYSICIAN RECRUITMENT	A	-522,527	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	LOBBYING EXPENSE	A	-49,823	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	TRANSFER TO PARENT	A	-11,548,525	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	HOSPICE PROFESSIONAL FEES	A	-23,977	HOSPICE	116.00	0	33.27
33.28	NURSING SCHOOL TUITION	B	-3,967,091	NURSING SCHOOL	20.00	0	33.28
33.29	LAB SCHOOL TUITION	B	-36,540	PARAMED ED PRGM-LABORATORY	23.02	0	33.29
33.30	HIM SCHOOL TUITION	B	-63,818	PARAMED ED PRGM-HIM	23.05	0	33.30
33.31	RT SCHOOL TUITION	B	-67,520	PARAMED ED PRGM-RESPIRATORY	23.04	0	33.31
33.32	MISCELLANEOUS INCOME	B	-370	NURSING SCHOOL	20.00	0	33.32
33.33	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	BOOK TO MEDICARE DEPRECIATION	A	40,874	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.34
33.35	GROUND FEES	B	-63,147	MAINTENANCE & REPAIRS	6.00	0	33.35
33.36	LABORATORY TUITION	B	-18,760	PARAMED ED PRGM-LABORATORY	23.02	0	33.36

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
12/30/2020 1:42 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00			
			3.00	4.00	5.00		
33.37 SELF-FUNDED HEALTH INSURANCE	A	-20,432,324	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.37
33.38 TRAUMA ON-CALL	A	-1,710,357	ADMINISTRATIVE & GENERAL	5.00		0	33.38
33.39 NON-HOSPITAL DEPRECIATION	A	-345,166	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.39
33.40 MISCELLANEOUS INCOME	B	-21,503	MEDICAL RECORDS & LIBRARY	16.00		0	33.40
33.41 MISCELLANEOUS INCOME	B	-57,000	ADMINISTRATIVE & GENERAL	5.00		0	33.41
33.42 MISCELLANEOUS INCOME	B	-1,170	NURSING ADMINISTRATION	13.00		0	33.42
33.43 MISCELLANEOUS INCOME	B	-2,830	RESPIRATORY THERAPY	65.00		0	33.43
33.44 MISCELLANEOUS INCOME	B	-6,249	ADMINISTRATIVE & GENERAL	5.00		0	33.44
33.45 MISCELLANEOUS INCOME	B	-315,623	ADMINISTRATIVE & GENERAL	5.00		0	33.45
33.46 MISCELLANEOUS INCOME	B	-166,667	DIETARY	10.00		0	33.46
33.47 MISCELLANEOUS INCOME	B	-76,408	LABORATORY	60.00		0	33.47
33.48 MISCELLANEOUS INCOME	B	-31,224	DRUGS CHARGED TO PATIENTS	73.00		0	33.48
33.49 MISCELLANEOUS INCOME	B	-1,459	ELECTROCARDIOLOGY	69.00		0	33.49
33.50 MISCELLANEOUS INCOME	B	-15,137	RADIOLOGY-DIAGNOSTIC	54.00		0	33.50
33.51 DOCTORS LOUNGE REVENUE	B	-106,776	DIETARY	10.00		0	33.51
33.52 CARE COORDINATION	B	-25,820	ADMINISTRATIVE & GENERAL	5.00		0	33.52
33.53 MISCELLANEOUS INCOME	B	-482,869	ADMINISTRATIVE & GENERAL	5.00		0	33.53
33.54 MISCELLANEOUS INCOME	B	78,858	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		0	33.54
33.55 OUTSIDE CATERING	B	-26,022	DIETARY	10.00		0	33.55
33.56 BH JAVA	B	-465,935	DIETARY	10.00		0	33.56
33.57 EMG RENTAL	B	-45,625	ELECTROENCEPHALOGRAPHY	70.00		0	33.57
33.58 BPS EXPENSES	A	-47,397,838	ADMINISTRATIVE & GENERAL	5.00		0	33.58
33.59 PHARMACY COVERAGE SALARIES	A	-39,641	DRUGS CHARGED TO PATIENTS	73.00		0	33.59
33.60 PHARMACY COVERAGE BENEFITS	A	-12,717	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.60
33.61 PHARMACY COVERAGE EXPENSES	A	-27,817	DRUGS CHARGED TO PATIENTS	73.00		0	33.61
33.62 INTEREST FROM INSURANCE	B	-321,475	ADMINISTRATIVE & GENERAL	5.00		0	33.62
33.63 OTHER OPERATING EXPENSES	A	-175,814	ADMINISTRATIVE & GENERAL	5.00		0	33.63
33.64 OTHER A&G EXPENSES	A	-120,037	ADMINISTRATIVE & GENERAL	5.00		0	33.64
33.65 PA AND NP IN EMERGENCY DEPT	A	-692,767	EMERGENCY	91.00		0	33.65
33.66 PA AND NP IN SURGURY	A	-92,997	OPERATING ROOM	50.00		0	33.66
33.67 PA AND NP IN ADULTS & PEDS	A	-756,004	ADULTS & PEDIATRICS	30.00		0	33.67
33.68 PA AND NP IN ICU	A	-62,114	INTENSIVE CARE UNIT	31.00		0	33.68
33.69 PA AND NP BENEFITS	A	-514,525	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.69
33.70 COLLEGE OF NURSING LOBBYING	A	-34,200	NURSING SCHOOL	20.00		0	33.70
33.71 LOBBYING EXPENSE	A	-2,513	SUBPROVIDER - IRF	41.00		0	33.71
33.72 MISCELLANEOUS INCOME	B	-182,880	DRUGS CHARGED TO PATIENTS	73.00		0	33.72
33.73 MISCELLANEOUS INCOME	B	-56,167	MAINTENANCE & REPAIRS	6.00		0	33.73
33.74 MISCELLANEOUS INCOME	B	-24,801	EMERGENCY	91.00		0	33.74
33.75 HOSPITAL SERVICES TO HOSPICE	A	194,162	HOSPICE	116.00		0	33.75
33.76 ER PHYSICIAN BENEFITS	A	-540,902	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.76
33.77 CV SURGEON BENEFITS	A	-79,592	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.77
33.78 ONCOLOGIST BENEFITS	A	-113,750	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.78
33.79 HOSPITALIST BENEFITS	A	-234,575	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.79
33.80 INTENSIVIST BENEFITS	A	-48,529	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.80
33.81 DEPRECIATION ADJUSTMENT	A	2,416	CAP REL COSTS-BUTLER BUILDING	1.01		9	33.81
33.82 DEPRECIATION ADJUSTMENT	A	-5,646,010	CAP REL COSTS-OLD BLDG & FIXTURES	1.02		9	33.82
33.83 DEPRECIATION ADJUSTMENT	A	6,864,427	CAP REL COSTS-NEW BLDG & FIXTURES	1.03		9	33.83
33.84 DEPRECIATION ADJUSTMENT	A	753,690	CAP REL COSTS-OAK STREET MALL	1.05		9	33.84
33.85 DEPRECIATION ADJUSTMENT	A	122,127	CAP REL COSTS-BRCN AT 36TH ST	1.06		9	33.85
33.86 DEPRECIATION ADJUSTMENT	A	3,564,415	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.86
33.87 DEPRECIATION ADJUSTMENT	A	-1,670,451	CAP REL COSTS-NEW BLDG & FIXTURES	1.03		9	33.87
33.88 DEPRECIATION ADJUSTMENT	A	-48,131	CAP REL COSTS-OLD BLDG & FIXTURES	1.02		9	33.88
33.89 CONTRACTED HOUSEKEEPING	A	-173,165	HOUSEKEEPING	9.00		0	33.89
33.90 CONTRACTED HOUSEKEEPING	A	525	ADMINISTRATIVE & GENERAL	5.00		0	33.90
33.91 COMMUNITY BENEFIT	A	-381,153	ADMINISTRATIVE & GENERAL	5.00		0	33.91
33.92 HOSPITAL VISITS BY RHC PROVIDER	A	-35,062	RURAL HEALTH CLINIC	88.00		0	33.92
33.93 COSTS FOR NON-RHC VISITS	A	-342	RURAL HEALTH CLINIC	88.00		0	33.93
33.94 SNU PHYSICIAN	A	-435	SKILLED NURSING FACILITY	44.00		0	33.94

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
12/30/2020 1:42 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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-149,078,514				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: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
12/30/2020 1:42 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	ADMINISTRATIVE & GENERAL	BIO-MED MAINTENANCE	303	636	1.00
2.00	6.00	MAINTENANCE & REPAIRS	BIO-MED MAINTENANCE	639,256	1,342,129	2.00
3.00	50.00	OPERATING ROOM	BIO-MED MAINTENANCE	9,143	19,196	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED MAINTENANCE	983	2,064	4.00
4.01	101.00	HOME HEALTH AGENCY	BIO-MED MAINTENANCE	598	1,256	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,637,335	1,652,538	4.02
4.03	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	83,490	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	39,268,799	17,406,729	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	6,108,621	0	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	500,780	4.06
4.07	1.04	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	11,362	71,426	4.07
4.08	10.00	DIETARY	DIETICIAN COSTS	0	4,683	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEFITS	0	1,502	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	DECISION SUPPORT WAGES	0	933,510	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	FISCAL SERVICES WAGES	0	1,014,529	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES WAGES	0	892,271	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS WAGES	0	6,997,587	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PURCHASING WAGES	0	808,380	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED DEPTS BENEFITS	0	5,928,315	4.15
4.16	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT WAGES	0	4,095,209	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	DECISION SUPPORT EXPENSES	0	4,347	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	FISCAL SERVICES EXPENSES	0	207,070	4.18
4.19	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES EXPENSES	0	774,292	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS EXPENSES	0	10,983,872	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	PURCHASING EXPENSES	0	753,652	4.21
4.22	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT EXPENSES	0	3,813	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY	HIM WAGES	0	3,737,881	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	PFS WAGES	0	3,515,194	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	PT ACCESS WAGES	0	2,574,293	4.25
4.26	4.00	EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE BENEFITS	0	5,711,605	4.26
4.27	16.00	MEDICAL RECORDS & LIBRARY	HIM EXPENSES	0	1,123,813	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	PFS EXPENSES	0	2,956,710	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	PT ACCESS EXPENSES	0	147,056	4.29
4.30	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES WAGES	0	19,487	4.30
4.31	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDIES BENEFITS	0	6,251	4.31
4.32	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES EXPENSES	0	2,292	4.32
4.33	30.00	ADULTS & PEDIATRICS	TELEMETRY WAGES	0	13,235	4.33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEMETRY BENEFITS	0	4,246	4.34
4.35	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER WAGES	0	56,041	4.35
4.36	4.00	EMPLOYEE BENEFITS DEPARTMENT	LOGISTICS MANAGER BENEFITS	0	17,978	4.36
4.37	5.00	ADMINISTRATIVE & GENERAL	OAK STREET MALL	0	128,223	4.37
4.38	1.05	CAP REL COSTS-OAK STREET MAL	OAK STREET MALL	167,183	0	4.38
4.39	1.05	CAP REL COSTS-OAK STREET MAL	BBC RENT FOR HIM, PFS, PT AC	0	84,090	4.39
4.40	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	0	5,965	4.40
4.41	13.00	NURSING ADMINISTRATION	HOME OFFICE	5,403,309	0	4.41
4.42	88.00	RURAL HEALTH CLINIC	HOME OFFICE	30,256	0	4.42
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			53,309,111	74,587,636	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	Related Organization(s) and/or Home Office	
			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

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

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
12/30/2020 1:42 pm

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00

reimbursement under title XVIII.

6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				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: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
12/30/2020 1:42 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	-333	0		1.00
2.00	-702,873	0		2.00
3.00	-10,053	0		3.00
4.00	-1,081	0		4.00
4.01	-658	0		4.01
4.02	-15,203	0		4.02
4.03	-51,527	0		4.03
4.04	21,862,070	0		4.04
4.05	6,108,621	0		4.05
4.06	-500,780	0		4.06
4.07	-60,064	10		4.07
4.08	-4,683	0		4.08
4.09	-1,502	0		4.09
4.10	-933,510	0		4.10
4.11	-1,014,529	0		4.11
4.12	-892,271	0		4.12
4.13	-6,997,587	0		4.13
4.14	-808,380	0		4.14
4.15	-5,928,315	0		4.15
4.16	-4,095,209	0		4.16
4.17	-4,347	0		4.17
4.18	-207,070	0		4.18
4.19	-774,292	0		4.19
4.20	-10,983,872	0		4.20
4.21	-753,652	0		4.21
4.22	-3,813	0		4.22
4.23	-3,737,881	0		4.23
4.24	-3,515,194	0		4.24
4.25	-2,574,293	0		4.25
4.26	-5,711,605	0		4.26
4.27	-1,123,813	0		4.27
4.28	-2,956,710	0		4.28
4.29	-147,056	0		4.29
4.30	-19,487	0		4.30
4.31	-6,251	0		4.31
4.32	-2,292	0		4.32
4.33	-13,235	0		4.33
4.34	-4,246	0		4.34
4.35	-56,041	0		4.35
4.36	-17,978	0		4.36
4.37	-128,223	0		4.37
4.38	167,183	10		4.38
4.39	-84,090	10		4.39
4.40	-5,965	9		4.40
4.41	5,403,309	0		4.41
4.42	30,256	0		4.42
5.00	-21,278,525			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	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00

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

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
12/30/2020 1:42 pm

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		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: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
12/30/2020 1:42 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	5.00	ADMINISTRATIVE & GENERAL	4,208,180	3,903,285	304,895	211,500	1,975	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	2,167	0	2,167	246,500	13	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	432,900	432,900	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	788,401	788,401	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	2,065,089	2,065,089	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	15,225	0	15,225	211,500	102	6.00
7.00	31.00	INTENSIVE CARE UNIT	464,370	464,370	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	54,530	0	54,530	246,400	200	8.00
9.00	40.00	SUBPROVIDER - IPF	1,440	0	1,440	181,300	8	9.00
10.00	30.00	ADULTS & PEDIATRICS	3,060	0	3,060	181,300	17	10.00
11.00	41.00	SUBPROVIDER - IRF	33,000	0	33,000	211,500	264	11.00
13.00	50.00	OPERATING ROOM	24,000	0	24,000	211,500	110	13.00
14.00	65.00	RESPIRATORY THERAPY	8,700	0	8,700	211,500	58	14.00
15.00	65.00	RESPIRATORY THERAPY	7,425	0	7,425	211,500	50	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	9,450	0	9,450	211,500	63	16.00
17.00	69.00	ELECTROCARDIOLOGY	5,282	0	5,282	211,500	41	17.00
18.00	69.00	ELECTROCARDIOLOGY	16,392	0	16,392	246,400	82	18.00
19.00	91.00	EMERGENCY	31,200	0	31,200	211,500	240	19.00
20.00	91.00	EMERGENCY	299,558	231,558	68,000	211,500	693	20.00
21.00	91.00	EMERGENCY	5,697,460	5,697,460	0	0	0	21.00
22.00	91.00	EMERGENCY	202,900	0	202,900	211,500	1,088	22.00
23.00	50.00	OPERATING ROOM	5,575	0	5,575	211,500	25	23.00
24.00	50.00	OPERATING ROOM	1,838	0	1,838	246,400	4	24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	11,766,030	11,766,030	0	0	0	25.00
26.00	54.00	RADIOLOGY-DIAGNOSTIC	1,366,608	1,366,608	0	0	0	26.00
27.00	50.00	OPERATING ROOM	224,403	224,403	0	0	0	27.00
28.00	50.00	OPERATING ROOM	879,935	879,935	0	0	0	28.00
200.00			28,615,118	27,820,039	795,079		5,033	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	5.00	ADMINISTRATIVE & GENERAL	200,823	10,041	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	1,541	77	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	10,372	519	0	0	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	23,692	1,185	0	0	0	8.00
9.00	40.00	SUBPROVIDER - IPF	697	35	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	1,482	74	0	0	0	10.00
11.00	41.00	SUBPROVIDER - IRF	26,844	1,342	0	0	0	11.00
13.00	50.00	OPERATING ROOM	11,185	559	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	5,898	295	0	0	0	14.00
15.00	65.00	RESPIRATORY THERAPY	5,084	254	0	0	0	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	6,406	320	0	0	0	16.00
17.00	69.00	ELECTROCARDIOLOGY	4,169	208	0	0	0	17.00
18.00	69.00	ELECTROCARDIOLOGY	9,714	486	0	0	0	18.00
19.00	91.00	EMERGENCY	24,404	1,220	0	0	0	19.00
20.00	91.00	EMERGENCY	70,466	3,523	0	0	0	20.00
21.00	91.00	EMERGENCY	0	0	0	0	0	21.00
22.00	91.00	EMERGENCY	110,631	5,532	0	0	0	22.00
23.00	50.00	OPERATING ROOM	2,542	127	0	0	0	23.00
24.00	50.00	OPERATING ROOM	474	24	0	0	0	24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	25.00
26.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	26.00
27.00	50.00	OPERATING ROOM	0	0	0	0	0	27.00
28.00	50.00	OPERATING ROOM	0	0	0	0	0	28.00
200.00			516,424	25,821	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	5.00	ADMINISTRATIVE & GENERAL	0	200,823	104,072	4,007,357		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	1,541	626	626		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	432,900		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	788,401		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,065,089		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	10,372	4,853	4,853		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	464,370		7.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
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	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		
8.00	31.00	INTENSIVE CARE UNIT	0	23,692	30,838	30,838		8.00
9.00	40.00	SUBPROVIDER - IPF	0	697	743	743		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	1,482	1,578	1,578		10.00
11.00	41.00	SUBPROVIDER - IRF	0	26,844	6,156	6,156		11.00
13.00	50.00	OPERATING ROOM	0	11,185	12,815	12,815		13.00
14.00	65.00	RESPIRATORY THERAPY	0	5,898	2,802	2,802		14.00
15.00	65.00	RESPIRATORY THERAPY	0	5,084	2,341	2,341		15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	0	6,406	3,044	3,044		16.00
17.00	69.00	ELECTROCARDIOLOGY	0	4,169	1,113	1,113		17.00
18.00	69.00	ELECTROCARDIOLOGY	0	9,714	6,678	6,678		18.00
19.00	91.00	EMERGENCY	0	24,404	6,796	6,796		19.00
20.00	91.00	EMERGENCY	0	70,466	0	231,558		20.00
21.00	91.00	EMERGENCY	0	0	0	5,697,460		21.00
22.00	91.00	EMERGENCY	0	110,631	92,269	92,269		22.00
23.00	50.00	OPERATING ROOM	0	2,542	3,033	3,033		23.00
24.00	50.00	OPERATING ROOM	0	474	1,364	1,364		24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	11,766,030		25.00
26.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,366,608		26.00
27.00	50.00	OPERATING ROOM	0	0	0	224,403		27.00
28.00	50.00	OPERATING ROOM	0	0	0	879,935		28.00
200.00			0	516,424	281,121	28,101,160		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	37,889	0	37,889			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	376,814	0	0	376,814		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	6,996,261	0	0	0	6,996,261	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	9,854	0	0	0	0	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	836,783	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	122,127	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	15,703,271					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,622,366	0	0	13,649	65,030	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	59,712,800	0	6,558	88,237	1,320,875	5.00
6.00	00600	MAINTENANCE & REPAIRS	8,397,455	0	0	61,706	831,954	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,701,674	0	0	5,954	16,501	8.00
9.00	00900	HOUSEKEEPING	4,610,616	0	0	12,240	22,401	9.00
10.00	01000	DIETARY	1,726,718	0	0	0	178,275	10.00
11.00	01100	CAFETERIA	2,985,990	0	0	0	70,267	11.00
13.00	01300	NURSING ADMINISTRATION	10,696,383	0	0	12,997	9,522	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,015,142	0	0	1,815	39,413	16.00
20.00	02000	NURSING SCHOOL	3,065,044	0	0	0	73,101	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,098,535	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,153,264	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	238,995	0	0	0	5,992	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	19,212	0	0	0	5,992	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	297,770	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	120,180	0	0	0	581	23.04
23.05	02305	PARAMED ED PRGM-HIM	164,504	0	0	0	1,742	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,627,529	0	0	1,306	1,790,889	30.00
31.00	03100	INTENSIVE CARE UNIT	4,503,901	0	0	30,753	130,478	31.00
40.00	04000	SUBPROVIDER - IPF	1,140,979	0	0	0	104,164	40.00
41.00	04100	SUBPROVIDER - IRF	1,784,901	0	0	14,446	55,450	41.00
43.00	04300	NURSERY	302,461	0	0	0	41,422	43.00
44.00	04400	SKILLED NURSING FACILITY	1,813,576	0	0	0	134,357	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,416,701	0	0	28,119	326,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	818,070	0	0	26,295	0	52.00
53.00	05300	ANESTHESIOLOGY	683,835	0	0	1,948	7,873	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,228,612	0	0	4,728	179,982	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,724,255	0	0	0	132,348	55.00
57.00	05700	CT SCAN	847,660	0	0	1,852	12,007	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	836,192	0	0	0	23,097	58.00
60.00	06000	LABORATORY	8,496,826	0	0	1,983	118,552	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,372,410	0	0	0	4,471	62.00
65.00	06500	RESPIRATORY THERAPY	2,624,592	0	0	5,656	0	65.00
66.00	06600	PHYSICAL THERAPY	1,491,307	0	0	0	39,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	886,023	0	0	0	19,068	67.00
68.00	06800	SPEECH PATHOLOGY	290,676	0	0	0	6,457	68.00
69.00	06900	ELECTROCARDIOLOGY	2,983,208	0	0	25,197	55,217	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	539,635	0	0	5,554	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,650,934	0	12,387	0	73,333	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,355,503	0	18,944	0	112,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,889,645	0	0	639	48,691	73.00
74.00	07400	RENAL DIALYSIS	970,953	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	948,907	0	0	0	0	88.00
90.00	09000	CLINIC	579,664	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	547,776	0	0	0	40,632	90.01
91.00	09100	EMERGENCY	6,539,601	0	0	16,835	185,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,024,613	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,244,687	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	288,875,279	0	37,889	361,909	6,283,765	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,541	9,255	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,963,735	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	11,612	193.01
193.02	19302	UNUSED SPACE	0	0	0	3,214	451,703	193.02
193.03	19303	HEALTH EDUCATION	6,708	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	2,150	239,926	193.04
193.05	19305	AUGUSTA PHARMACY	923,919	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	291,769,641	0	37,889	376,814	6,996,261	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT			
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP				
			1.04	1.05	1.06	2.00	4.00			
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS-BLDG & FIXT							1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING							1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES							1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES							1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I	9,854						1.04	
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	836,783					1.05	
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	122,127				1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				15,703,271			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	136,725	13,837,770		4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	9,854	540,826	0	6,303,610	1,306,580		5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	6,227	0	334,256	408,318		6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,130	5,376		8.00	
9.00	00900	HOUSEKEEPING	0	428	0	69,695	374,542		9.00	
10.00	01000	DIETARY	0	0	0	183,476	126,042		10.00	
11.00	01100	CAFETERIA	0	0	0	0	231,259		11.00	
13.00	01300	NURSING ADMINISTRATION	0	56,764	0	796,435	604,328		13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,315	0	67,613	0		16.00	
20.00	02000	NURSING SCHOOL	0	79,064	118,352	181,333	609,801		20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	141,797		21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	750	0		22.00	
23.00	02300	PARAMED ED PRGM	0	0	0	0	0		23.00	
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,676	0	5,858	38,979		23.01	
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,343	9,524		23.02	
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	38,514		23.03	
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	635	944	1,445	20,557		23.04	
23.05	02305	PARAMED ED PRGM-HIM	0	1,892	2,831	4,335	19,366		23.05	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,289,676	2,831,655		30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	157,707	533,352		31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	2,398	144,031		40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	8,811	212,467		41.00	
43.00	04300	NURSERY	0	0	0	23,185	34,608		43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,007	202,282		44.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0	0	0	2,384,136	1,264,452		50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,019	84,779		52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	67,099	23,384		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	615,462	462,995		54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	604,928	153,439		55.00	
57.00	05700	CT SCAN	0	0	0	320,121	78,799		57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	60,602	47,439		58.00	
60.00	06000	LABORATORY	0	0	0	298,546	414,678		60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	15,750	21,712		62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	295,529		65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	7,348	190,364		66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,082	114,009		67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,821	36,852		68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	835,368	284,295		69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	67,116	60,660		70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	73,346	44,102		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	112,246	67,492		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	356,007	619,919		73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	7,659	0		74.00	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88,952		88.00	
90.00	09000	CLINIC	0	0	0	0	63,803		90.00	
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	60,216		90.01	
91.00	09100	EMERGENCY	0	31,827	0	132,974	602,562		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		92.00	
OTHER REIMBURSABLE COST CENTERS										
101.00	10100	HOME HEALTH AGENCY	0	28,306	0	641	401,460		101.00	
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE	0	0	0	0	0		113.00	
116.00	11600	HOSPICE	0	0	0	7,099	188,577		116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,854	827,960	122,127	15,571,158	13,563,847		118.00	
NONREIMBURSABLE COST CENTERS										
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	129,015	243,671		192.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0		193.00	
193.01	19301	DENMAN SERVICES	0	0	0	0	0		193.01	

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
			1.04	1.05	1.06	2.00	4.00	
193.02	19302	UNUSED SPACE	0	8,823	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	863	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	3,098	29,389	193.05
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)	9,854	836,783	122,127	15,703,271	13,837,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	69,289,340	69,289,340				5.00
6.00	00600	MAINTENANCE & REPAIRS	10,039,916	3,126,831	13,166,747			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,733,635	539,923	74,391	2,347,949		8.00
9.00	00900	HOUSEKEEPING	5,089,922	1,585,205	131,521	21,338	6,827,986	9.00
10.00	01000	DIETARY	2,214,511	689,687	341,933	22,836	226,285	10.00
11.00	01100	CAFETERIA	3,287,516	1,023,864	134,773	0	89,207	11.00
13.00	01300	NURSING ADMINISTRATION	12,176,429	3,792,227	203,128	0	134,405	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,186,298	1,926,661	189,141	0	125,140	16.00
20.00	02000	NURSING SCHOOL	4,126,695	1,285,218	966,129	0	639,240	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,240,332	386,289	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,154,014	670,846	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	309,500	96,391	43,232	0	28,627	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	36,071	11,234	11,493	0	7,602	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	336,284	104,732	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	144,342	44,954	7,706	0	5,108	23.04
23.05	02305	PARAMED ED PRGM-HIM	194,670	60,628	23,097	0	15,323	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,541,055	9,511,785	3,444,318	846,850	2,279,185	30.00
31.00	03100	INTENSIVE CARE UNIT	5,356,191	1,668,132	471,026	144,305	311,691	31.00
40.00	04000	SUBPROVIDER - IPF	1,391,572	433,391	199,787	6,536	132,207	40.00
41.00	04100	SUBPROVIDER - IRF	2,076,075	646,573	210,055	181,844	138,978	41.00
43.00	04300	NURSERY	401,676	125,098	79,447	14,189	52,562	43.00
44.00	04400	SKILLED NURSING FACILITY	2,151,222	669,977	257,697	89,244	170,516	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,419,522	6,048,016	827,347	167,765	547,479	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	955,163	297,476	188,762	64,642	124,902	52.00
53.00	05300	ANESTHESIOLOGY	784,139	244,212	29,088	0	19,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,491,779	2,021,800	379,151	150,040	250,873	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,614,970	814,406	253,844	82,222	167,962	55.00
57.00	05700	CT SCAN	1,260,439	392,551	36,327	55,034	24,054	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	967,330	301,265	44,301	12,189	29,340	58.00
60.00	06000	LABORATORY	9,330,585	2,905,917	241,616	207	159,884	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,414,343	440,483	8,575	0	5,702	62.00
65.00	06500	RESPIRATORY THERAPY	2,925,777	911,204	40,603	0	26,845	65.00
66.00	06600	PHYSICAL THERAPY	1,728,478	538,317	75,683	0	50,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,022,182	318,348	36,572	0	24,173	67.00
68.00	06800	SPEECH PATHOLOGY	335,806	104,583	12,384	0	8,196	68.00
69.00	06900	ELECTROCARDIOLOGY	4,183,285	1,302,842	286,785	84,716	189,759	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	672,965	209,588	39,868	638	26,370	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,854,102	4,003,282	148,604	12,113	98,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,666,408	5,190,586	227,406	18,536	150,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,914,901	8,070,937	97,978	0	64,856	73.00
74.00	07400	RENAL DIALYSIS	978,612	304,779	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,037,859	323,231	0	0	0	88.00
90.00	09000	CLINIC	643,467	200,401	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	648,624	202,007	77,933	694	51,553	90.01
91.00	09100	EMERGENCY	7,509,634	2,338,800	528,624	364,284	349,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,455,020	1,387,471	45,659	0	30,231	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,440,363	760,027	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	287,733,019	68,032,175	10,415,984	2,340,222	6,756,181	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,796	5,854	86,240	7,727	57,076	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,336,421	727,655	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	11,612	3,616	22,273	0	14,729	193.01
193.02	19302	UNUSED SPACE	463,740	144,427	903,676	0	0	193.02
193.03	19303	HEALTH EDUCATION	7,571	2,358	0	0	0	193.03
193.04	19304	RENTED SPACE	242,076	75,392	1,738,574	0	0	193.04

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			4A	5.00	6.00	8.00	9.00	
193.05	19305	AUGUSTA PHARMACY	956,406	297,863	0	0	0	193.05
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)	291,769,641	69,289,340	13,166,747	2,347,949	6,827,986	202.00

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	3,495,252					10.00
11.00	01100	CAFETERIA	0	4,535,360				11.00
13.00	01300	NURSING ADMINISTRATION	0	256,560	16,562,749			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	8,427,240		16.00
20.00	02000	NURSING SCHOOL	0	217,124	0	0	7,234,406	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	64,493	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	13,445	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,484	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	12,283	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	7,698	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	0	1,748	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,529,854	1,372,648	7,611,279	6,064,807	5,664,030	30.00
31.00	03100	INTENSIVE CARE UNIT	283,825	220,512	1,222,746	680,403	499,008	31.00
40.00	04000	SUBPROVIDER - IPF	161,779	79,901	443,066	387,810	110,202	40.00
41.00	04100	SUBPROVIDER - IRF	243,833	89,766	497,717	584,563	35,816	41.00
43.00	04300	NURSERY	0	11,996	66,522	13,100	92,638	43.00
44.00	04400	SKILLED NURSING FACILITY	275,961	97,344	539,755	661,556	30,650	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	527,606	2,925,519	0	190,098	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	36,419	201,909	0	270,683	52.00
53.00	05300	ANESTHESIOLOGY	0	17,599	97,600	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	189,517	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	49,995	0	0	0	55.00
57.00	05700	CT SCAN	0	31,223	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,862	0	0	0	58.00
60.00	06000	LABORATORY	0	228,150	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11,816	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	124,772	0	0	2,755	65.00
66.00	06600	PHYSICAL THERAPY	0	64,780	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,286	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,457	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	104,420	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	29,535	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,935	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55,921	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	185,901	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	20,855	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	25,943	143,833	0	0	90.01
91.00	09100	EMERGENCY	0	278,959	1,546,775	35,001	275,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	834,434	0	39,948	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	431,594	0	22,729	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,495,252	4,534,953	16,562,749	8,427,240	7,234,406	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	407	0	0	0	193.03

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
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)	3,495,252	4,535,360	16,562,749	8,427,240	7,234,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
			23.00	23.01	23.02			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,626,621					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,889,353				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				491,195		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					69,884	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY						23.04
23.05	02305	PARAMED ED PRGM-HIM						23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,108,894	1,969,717	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	76,148	135,261	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,907	6,940	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	51,669	91,779	0	0	0	41.00
43.00	04300	NURSERY	41,303	73,367	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	86,514	153,674	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,917	22,945	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,010	16,005	0	491,195	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	10,366	18,413	0	0	69,884	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	55,496	98,578	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50,314	89,372	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	120,083	213,302	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,626,621	2,889,353	0	491,195	69,884	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,626,621	2,889,353	0	491,195	69,884	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	453,299					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		209,808				23.04
23.05	02305	PARAMED ED PRGM-HIM			295,466			23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	212,638	73,157,060	-3,078,611	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	23,855	11,093,103	-211,409	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	13,597	3,370,695	-10,847	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	20,495	4,869,163	-143,448	41.00
43.00	04300	NURSERY	0	0	459	972,357	-114,670	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	23,195	4,967,117	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	30,893,540	-240,188	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,139,956	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,227,743	-35,862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,999,370	-25,015	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,983,399	0	55.00
57.00	05700	CT SCAN	0	0	0	1,799,628	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,372,287	0	58.00
60.00	06000	LABORATORY	0	0	0	12,965,022	-28,779	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,880,919	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	209,808	0	4,241,764	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,457,326	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,441,561	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	472,426	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,305,881	-154,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,118,650	-139,686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,149,330	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,309,357	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	453,299	0	0	34,787,872	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,283,391	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,361,090	0	88.00
90.00	09000	CLINIC	0	0	0	864,723	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	1,150,587	0	90.01
91.00	09100	EMERGENCY	0	0	1,227	13,562,359	-333,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	6,792,763	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	3,654,713	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	453,299	209,808	295,466	283,645,152	-4,515,974	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	175,693	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	3,064,076	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	52,230	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
193.02	19302	UNUSED SPACE	0	0	0	1,511,843	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	10,336	0	193.03
193.04	19304	RENTED SPACE	0	0	0	2,056,042	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	1,254,269	0	193.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	453,299	209,808	295,466	291,769,641	-4,515,974	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT INFUSION	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	DENMAN SERVICES	193.01
193.02	19302	UNUSED SPACE	193.02
193.03	19303	HEALTH EDUCATION	193.03
193.04	19304	RENTED SPACE	193.04
193.05	19305	AUGUSTA PHARMACY	193.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	287,253,667	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
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			CAPITAL RELATED COSTS					
Cost Center Description			Directly Assigned New Capital Related Costs	BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,812	0	0	13,649	65,030	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	745,766	0	6,558	88,237	1,320,875	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	61,706	831,954	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	5,954	16,501	8.00
9.00	00900	HOUSEKEEPING	0	0	0	12,240	22,401	9.00
10.00	01000	DIETARY	9,259	0	0	0	178,275	10.00
11.00	01100	CAFETERIA	0	0	0	0	70,267	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	12,997	9,522	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,815	39,413	16.00
20.00	02000	NURSING SCHOOL	571,242	0	0	0	73,101	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	5,992	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	5,992	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	0	581	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	0	1,742	23.05
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	72,524	0	0	1,306	1,790,889	30.00
31.00	03100	INTENSIVE CARE UNIT	11,379	0	0	30,753	130,478	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	104,164	40.00
41.00	04100	SUBPROVIDER - IRF	8,326	0	0	14,446	55,450	41.00
43.00	04300	NURSERY	0	0	0	0	41,422	43.00
44.00	04400	SKILLED NURSING FACILITY	9,238	0	0	0	134,357	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,080,848	0	0	28,119	326,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,295	0	52.00
53.00	05300	ANESTHESIOLOGY	26,524	0	0	1,948	7,873	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	314,513	0	0	4,728	179,982	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	132,348	55.00
57.00	05700	CT SCAN	0	0	0	1,852	12,007	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	23,097	58.00
60.00	06000	LABORATORY	140,748	0	0	1,983	118,552	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	4,471	62.00
65.00	06500	RESPIRATORY THERAPY	100,283	0	0	5,656	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	39,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	19,068	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	6,457	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,197	55,217	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,894	0	0	5,554	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,387	0	73,333	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,944	0	112,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	639	48,691	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	43,644	0	0	0	0	88.00
90.00	09000	CLINIC	69,803	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	40,632	90.01
91.00	09100	EMERGENCY	0	0	0	16,835	185,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,081	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	145,117	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,428,001	0	37,889	361,909	6,283,765	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,541	9,255	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
				1.00	1.01	1.02	1.03	
193.01	19301	DENMAN SERVICES	0	0	0	0	11,612	193.01
193.02	19302	UNUSED SPACE	0	0	0	3,214	451,703	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	2,150	239,926	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,428,001	0	37,889	376,814	6,996,261	202.00

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Cost Center Description		CAPITAL RELATED COSTS				Subtotal	
		MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
		1.04	1.05	1.06	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	136,725	236,216
5.00	00500	ADMINISTRATIVE & GENERAL	9,854	540,826	0	6,303,610	9,015,726
6.00	00600	MAINTENANCE & REPAIRS	0	6,227	0	334,256	1,234,143
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,130	26,585
9.00	00900	HOUSEKEEPING	0	428	0	69,695	104,764
10.00	01000	DIETARY	0	0	0	183,476	371,010
11.00	01100	CAFETERIA	0	0	0	0	70,267
13.00	01300	NURSING ADMINISTRATION	0	56,764	0	796,435	875,718
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,315	0	67,613	171,156
20.00	02000	NURSING SCHOOL	0	79,064	118,352	181,333	1,023,092
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	750	750
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,676	0	5,858	31,526
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,343	7,335
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	635	944	1,445	3,605
23.05	02305	PARAMED ED PRGM-HIM	0	1,892	2,831	4,335	10,800
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,289,676	3,154,395
31.00	03100	INTENSIVE CARE UNIT	0	0	0	157,707	330,317
40.00	04000	SUBPROVIDER - IPF	0	0	0	2,398	106,562
41.00	04100	SUBPROVIDER - IRF	0	0	0	8,811	87,033
43.00	04300	NURSERY	0	0	0	23,185	64,607
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,007	144,602
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,384,136	3,819,217
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,019	52,314
53.00	05300	ANESTHESIOLOGY	0	0	0	67,099	103,444
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	615,462	1,114,685
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	604,928	737,276
57.00	05700	CT SCAN	0	0	0	320,121	333,980
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	60,602	83,699
60.00	06000	LABORATORY	0	0	0	298,546	559,829
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	15,750	20,221
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	105,939
66.00	06600	PHYSICAL THERAPY	0	0	0	7,348	46,807
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,082	22,150
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,821	8,278
69.00	06900	ELECTROCARDIOLOGY	0	0	0	835,368	915,782
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	67,116	128,564
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	73,346	159,066
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	112,246	243,413
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	356,007	405,337
74.00	07400	RENAL DIALYSIS	0	0	0	7,659	7,659
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	43,644
90.00	09000	CLINIC	0	0	0	0	69,803
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	40,632
91.00	09100	EMERGENCY	0	31,827	0	132,974	367,471
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	28,306	0	641	31,028
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	7,099	152,216
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,854	827,960	122,127	15,571,158	26,642,663
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	18,796
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	129,015	129,015
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	DENMAN SERVICES	0	0	0	0	11,612
193.02	19302	UNUSED SPACE	0	8,823	0	0	463,740

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS				Subtotal	
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
			1.04	1.05	1.06	2.00		
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	242,076	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	3,098	3,098	193.05
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)	9,854	836,783	122,127	15,703,271	27,511,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	236,216					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,300	9,038,026				5.00
6.00	00600	MAINTENANCE & REPAIRS	6,969	407,862	1,648,974			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	92	70,427	9,317	106,421		8.00
9.00	00900	HOUSEKEEPING	6,392	206,773	16,471	967	335,367	9.00
10.00	01000	DIETARY	2,151	89,962	42,823	1,035	11,114	10.00
11.00	01100	CAFETERIA	3,947	133,552	16,879	0	4,382	11.00
13.00	01300	NURSING ADMINISTRATION	10,314	494,655	25,439	0	6,602	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	251,312	23,688	0	6,146	16.00
20.00	02000	NURSING SCHOOL	10,408	167,643	120,996	0	31,397	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,420	50,387	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	87,505	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	665	12,573	5,414	0	1,406	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	163	1,465	1,439	0	373	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	657	13,661	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	351	5,864	965	0	251	23.04
23.05	02305	PARAMED ED PRGM-HIM	331	7,908	2,893	0	753	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,370	1,240,684	431,359	38,385	111,946	30.00
31.00	03100	INTENSIVE CARE UNIT	9,103	217,590	58,990	6,541	15,309	31.00
40.00	04000	SUBPROVIDER - IPF	2,458	56,531	25,021	296	6,494	40.00
41.00	04100	SUBPROVIDER - IRF	3,626	84,338	26,307	8,242	6,826	41.00
43.00	04300	NURSERY	591	16,318	9,950	643	2,582	43.00
44.00	04400	SKILLED NURSING FACILITY	3,452	87,391	32,273	4,045	8,375	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,581	788,899	103,615	7,604	26,890	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,447	38,803	23,640	2,930	6,135	52.00
53.00	05300	ANESTHESIOLOGY	399	31,855	3,643	0	945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,902	263,722	47,484	6,801	12,322	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,619	106,231	31,791	3,727	8,250	55.00
57.00	05700	CT SCAN	1,345	51,204	4,550	2,494	1,181	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	810	39,297	5,548	552	1,441	58.00
60.00	06000	LABORATORY	7,077	379,046	30,259	9	7,853	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	371	57,456	1,074	0	280	62.00
65.00	06500	RESPIRATORY THERAPY	5,044	118,857	5,085	0	1,319	65.00
66.00	06600	PHYSICAL THERAPY	3,249	70,218	9,478	0	2,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,946	41,525	4,580	0	1,187	67.00
68.00	06800	SPEECH PATHOLOGY	629	13,642	1,551	0	403	68.00
69.00	06900	ELECTROCARDIOLOGY	4,852	169,942	35,916	3,840	9,320	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,035	27,339	4,993	29	1,295	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	753	522,185	18,611	549	4,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,152	677,056	28,480	840	7,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,580	1,052,767	12,271	0	3,186	73.00
74.00	07400	RENAL DIALYSIS	0	39,755	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,518	42,162	0	0	0	88.00
90.00	09000	CLINIC	1,089	26,140	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	1,028	26,350	9,760	31	2,532	90.01
91.00	09100	EMERGENCY	10,284	305,071	66,204	16,511	17,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,852	180,981	5,718	0	1,485	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,218	99,137	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	231,540	8,874,041	1,304,475	106,071	331,841	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	764	10,801	350	2,803	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,159	94,915	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	472	2,789	0	723	193.01
193.02	19302	UNUSED SPACE	0	18,839	113,174	0	0	193.02
193.03	19303	HEALTH EDUCATION	15	308	0	0	0	193.03

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
193.04	19304	RENTED SPACE	0	9,834	217,735	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	502	38,853	0	0	0	193.05
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)	236,216	9,038,026	1,648,974	106,421	335,367	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	518,095					10.00
11.00	01100	CAFETERIA	0	229,027				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,956	1,425,684			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	452,302		16.00
20.00	02000	NURSING SCHOOL	0	10,964	0	0	1,364,500	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	3,257	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	679	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	176	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	620	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	389	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	0	88	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	374,996	69,315	655,162	325,507		30.00
31.00	03100	INTENSIVE CARE UNIT	42,071	11,135	105,251	36,518		31.00
40.00	04000	SUBPROVIDER - IPF	23,980	4,035	38,138	20,814		40.00
41.00	04100	SUBPROVIDER - IRF	36,143	4,533	42,842	31,374		41.00
43.00	04300	NURSERY	0	606	5,726	703		43.00
44.00	04400	SKILLED NURSING FACILITY	40,905	4,916	46,461	35,507		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,643	251,822	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,839	17,380	0		52.00
53.00	05300	ANESTHESIOLOGY	0	889	8,401	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,570	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,525	0	0		55.00
57.00	05700	CT SCAN	0	1,577	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	902	0	0		58.00
60.00	06000	LABORATORY	0	11,521	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	597	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	6,301	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,271	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,034	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	579	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,273	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,491	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,663	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,824	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,388	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	1,053	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	1,310	12,381	0		90.01
91.00	09100	EMERGENCY	0	14,087	133,143	1,879		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	71,826	0		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	37,151	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	518,095	229,006	1,425,684	452,302	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	DENMAN SERVICES	0	0	0	0		193.01
193.02	19302	UNUSED SPACE	0	0	0	0		193.02
193.03	19303	HEALTH EDUCATION	0	21	0	0		193.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.04	19304	RENTED SPACE	0	0	0	0		193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0		193.05
200.00		Cross Foot Adjustments					1,364,500	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	518,095	229,027	1,425,684	452,302	1,364,500	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
			21.00	22.00	23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,807	91,512	0	52,263	10,951	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY						23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
40.00	04000	SUBPROVIDER - IPF						40.00
41.00	04100	SUBPROVIDER - IRF						41.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
57.00	05700	CT SCAN						57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)						58.00
60.00	06000	LABORATORY						60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
68.00	06800	SPEECH PATHOLOGY						68.00
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
74.00	07400	RENAL DIALYSIS						74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC						90.00
90.01	09001	OUTPATIENT INFUSION						90.01
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY						101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
193.00	19300	NONPAID WORKERS						193.00
193.01	19301	DENMAN SERVICES						193.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.02	19302	UNUSED SPACE						193.02
193.03	19303	HEALTH EDUCATION						193.03
193.04	19304	RENTED SPACE						193.04
193.05	19305	AUGUSTA PHARMACY						193.05
200.00		Cross Foot Adjustments	52,807	91,512	0	52,263	10,951	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,807	91,512	0	52,263	10,951	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	14,938					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		11,425				23.04
23.05	02305	PARAMED ED PRGM-HIM			22,773			23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				6,450,119	0	30.00
31.00	03100	INTENSIVE CARE UNIT				832,825	0	31.00
40.00	04000	SUBPROVIDER - IPF				284,329	0	40.00
41.00	04100	SUBPROVIDER - IRF				331,264	0	41.00
43.00	04300	NURSERY				101,726	0	43.00
44.00	04400	SKILLED NURSING FACILITY				407,927	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				5,046,271	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				144,488	0	52.00
53.00	05300	ANESTHESIOLOGY				149,576	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,462,486	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				892,419	0	55.00
57.00	05700	CT SCAN				396,331	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)				132,249	0	58.00
60.00	06000	LABORATORY				995,594	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				79,999	0	62.00
65.00	06500	RESPIRATORY THERAPY				242,545	0	65.00
66.00	06600	PHYSICAL THERAPY				135,482	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				73,422	0	67.00
68.00	06800	SPEECH PATHOLOGY				25,082	0	68.00
69.00	06900	ELECTROCARDIOLOGY				1,144,925	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				164,746	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				707,655	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				961,157	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,493,529	0	73.00
74.00	07400	RENAL DIALYSIS				47,414	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				87,324	0	88.00
90.00	09000	CLINIC				98,085	0	90.00
90.01	09001	OUTPATIENT INFUSION				94,024	0	90.01
91.00	09100	EMERGENCY				931,832	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY				297,890	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE				291,722	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	24,504,437	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				33,514	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				228,089	0	192.00
193.00	19300	NONPAID WORKERS				0	0	193.00
193.01	19301	DENMAN SERVICES				15,596	0	193.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
193.02	19302	UNUSED SPACE				595,753	0	193.02
193.03	19303	HEALTH EDUCATION				344	0	193.03
193.04	19304	RENTED SPACE				469,645	0	193.04
193.05	19305	AUGUSTA PHARMACY				42,453	0	193.05
200.00		Cross Foot Adjustments	14,938	11,425	22,773	1,621,169	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,938	11,425	22,773	27,511,000	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT INFUSION	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	DENMAN SERVICES	193.01
193.02	19302	UNUSED SPACE	193.02
193.03	19303	HEALTH EDUCATION	193.03
193.04	19304	RENTED SPACE	193.04
193.05	19305	AUGUSTA PHARMACY	193.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	1,621,169	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	27,511,000	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	1,092				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	121,449			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	602,477		1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	0	0	0	0	2,472	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,399	5,600	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	189	28,439	113,746	2,472	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	19,888	71,643	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,919	1,421	0	8.00
9.00	00900	HOUSEKEEPING	0	0	3,945	1,929	0	9.00
10.00	01000	DIETARY	0	0	0	15,352	0	10.00
11.00	01100	CAFETERIA	0	0	0	6,051	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,189	820	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	585	3,394	0	16.00
20.00	02000	NURSING SCHOOL	0	0	0	6,295	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	516	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	50	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	150	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	421	154,221	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	9,912	11,236	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	8,970	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,656	4,775	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,570	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	9,063	28,083	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	8,475	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,524	15,499	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	11,397	0	55.00
57.00	05700	CT SCAN	0	0	597	1,034	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,989	0	58.00
60.00	06000	LABORATORY	0	0	639	10,209	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,823	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,121	4,755	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,790	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	357	0	6,315	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	546	0	9,664	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	206	4,193	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,499	0	90.01
91.00	09100	EMERGENCY	0	0	5,426	16,003	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,092	116,645	541,121	2,472	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,075	797	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	1,000	0	193.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
193.02	19302	UNUSED SPACE	0	0	1,036	38,898	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	693	20,661	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
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)	0	37,889	376,814	6,996,261	9,854	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	34.696886	3.102652	11.612495	3.986246	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.05	1.06	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	60,602					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	32,356				1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP			15,693,570			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	136,641	107,204,942		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,168	0	6,299,712	10,122,410	-69,289,340	5.00
6.00	00600	MAINTENANCE & REPAIRS	451	0	334,050	3,163,340	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4,127	41,646	0	8.00
9.00	00900	HOUSEKEEPING	31	0	69,652	2,901,671	0	9.00
10.00	01000	DIETARY	0	0	183,363	976,483	0	10.00
11.00	01100	CAFETERIA	0	0	0	1,791,623	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,111	0	795,943	4,681,880	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,513	0	67,571	0	0	16.00
20.00	02000	NURSING SCHOOL	5,726	31,356	181,221	4,724,281	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,098,535	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	750	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,425	0	5,854	301,982	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	1,342	73,783	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	298,376	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	46	250	1,444	159,258	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	137	750	4,332	150,035	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	1,288,879	21,937,789	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	157,610	4,132,011	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,397	1,115,845	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	8,806	1,646,038	0	41.00
43.00	04300	NURSERY	0	0	23,171	268,116	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,006	1,567,128	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	2,382,664	9,796,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	26,003	656,805	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	67,058	181,162	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	615,082	3,586,936	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	604,554	1,188,734	0	55.00
57.00	05700	CT SCAN	0	0	319,923	610,477	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	60,565	367,525	0	58.00
60.00	06000	LABORATORY	0	0	298,362	3,212,612	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	15,740	168,208	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,289,539	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,343	1,474,801	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,080	883,254	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,820	285,504	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	834,852	2,202,502	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	67,075	469,950	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	73,301	341,670	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	112,177	522,879	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	355,787	4,802,666	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	7,654	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	689,135	0	88.00
90.00	09000	CLINIC	0	0	0	494,297	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	466,512	0	90.01
91.00	09100	EMERGENCY	2,305	0	132,892	4,668,203	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,050	0	641	3,110,211	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	7,095	1,460,952	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,963	32,356	15,561,539	105,082,791	-69,289,340	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	128,935	1,887,778	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.05	1.06	2.00	4.00	5A	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	639	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	6,688	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	3,096	227,685	0	193.05
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)	836,783	122,127	15,703,271	13,837,770		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.807845	3.774478	1.000618	0.129078		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				236,216		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.002203		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: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	222,480,301				5.00
6.00	00600	MAINTENANCE & REPAIRS	10,039,916	591,157			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,733,635	3,340	1,692,777		8.00
9.00	00900	HOUSEKEEPING	5,089,922	5,905	15,384	114,964	9.00
10.00	01000	DIETARY	2,214,511	15,352	16,464	3,810	10.00
11.00	01100	CAFETERIA	3,287,516	6,051	0	1,502	11.00
13.00	01300	NURSING ADMINISTRATION	12,176,429	9,120	0	2,263	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,186,298	8,492	0	2,107	16.00
20.00	02000	NURSING SCHOOL	4,126,695	43,377	0	10,763	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,240,332	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,154,014	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	309,500	1,941	0	482	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	36,071	516	0	128	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	336,284	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	144,342	346	0	86	23.04
23.05	02305	PARAMED ED PRGM-HIM	194,670	1,037	0	258	23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,541,055	154,642	610,545	38,375	30.00
31.00	03100	INTENSIVE CARE UNIT	5,356,191	21,148	104,038	5,248	31.00
40.00	04000	SUBPROVIDER - IPF	1,391,572	8,970	4,712	3,127	40.00
41.00	04100	SUBPROVIDER - IRF	2,076,075	9,431	131,102	2,340	41.00
43.00	04300	NURSERY	401,676	3,567	10,230	885	43.00
44.00	04400	SKILLED NURSING FACILITY	2,151,222	11,570	64,341	2,871	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,419,522	37,146	120,952	9,218	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	955,163	8,475	46,604	2,103	52.00
53.00	05300	ANESTHESIOLOGY	784,139	1,306	0	324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,491,779	17,023	108,173	4,224	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,614,970	11,397	59,279	2,828	55.00
57.00	05700	CT SCAN	1,260,439	1,631	39,677	405	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	967,330	1,989	8,788	494	58.00
60.00	06000	LABORATORY	9,330,585	10,848	149	2,692	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,414,343	385	0	96	62.00
65.00	06500	RESPIRATORY THERAPY	2,925,777	1,823	0	452	65.00
66.00	06600	PHYSICAL THERAPY	1,728,478	3,398	0	843	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,022,182	1,642	0	407	67.00
68.00	06800	SPEECH PATHOLOGY	335,806	556	0	138	68.00
69.00	06900	ELECTROCARDIOLOGY	4,183,285	12,876	61,077	3,195	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	672,965	1,790	460	444	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,854,102	6,672	8,733	1,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,666,408	10,210	13,364	2,534	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,914,901	4,399	0	1,092	73.00
74.00	07400	RENAL DIALYSIS	978,612	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,037,859	0	0	0	88.00
90.00	09000	CLINIC	643,467	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	648,624	3,499	500	868	90.01
91.00	09100	EMERGENCY	7,509,634	23,734	262,634	5,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	4,455,020	2,050	0	509	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	2,440,363	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,443,679	467,654	1,687,206	113,755	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,796	3,872	5,571	961	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,336,421	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	11,612	1,000	0	248	193.01
193.02	19302	UNUSED SPACE	463,740	40,573	0	0	193.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	6.00	8.00	9.00	10.00	
193.03	19303	HEALTH EDUCATION	7,571	0	0	0	0	193.03
193.04	19304	RENTED SPACE	242,076	78,058	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	956,406	0	0	0	0	193.05
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)	69,289,340	13,166,747	2,347,949	6,827,986	3,495,252	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.311440	22.272843	1.387040	59.392384	51.736290	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,038,026	1,648,974	106,421	335,367	518,095	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040624	2.789401	0.062868	2.917148	7.668778	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: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
		11.00	13.00	16.00	20.00	21.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	378,831				11.00
13.00	01300	NURSING ADMINISTRATION	21,430	1,745,370			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	162,760		16.00
20.00	02000	NURSING SCHOOL	18,136	0	0	21,007	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	20,400	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,387	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,123	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	291	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	1,026	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	643	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	146	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	114,655	802,071	117,133	16,447	30.00
31.00	03100	INTENSIVE CARE UNIT	18,419	128,852	13,141	1,449	31.00
40.00	04000	SUBPROVIDER - IPF	6,674	46,690	7,490	320	40.00
41.00	04100	SUBPROVIDER - IRF	7,498	52,449	11,290	104	41.00
43.00	04300	NURSERY	1,002	7,010	253	269	43.00
44.00	04400	SKILLED NURSING FACILITY	8,131	56,879	12,777	89	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,070	308,289	0	552	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,042	21,277	0	786	52.00
53.00	05300	ANESTHESIOLOGY	1,470	10,285	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,830	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,176	0	0	0	55.00
57.00	05700	CT SCAN	2,608	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,492	0	0	0	58.00
60.00	06000	LABORATORY	19,057	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	987	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,422	0	0	8	65.00
66.00	06600	PHYSICAL THERAPY	5,411	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,365	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	957	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,722	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,467	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,751	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,671	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,528	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	1,742	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	2,167	15,157	0	0	90.01
91.00	09100	EMERGENCY	23,301	162,998	676	801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,506	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	87,932	0	116	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	45,481	0	66	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	378,797	1,745,370	162,760	21,007	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
			11.00	13.00	16.00	20.00	21.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	34	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,535,360	16,562,749	8,427,240	7,234,406	1,626,621	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.971988	9.489535	51.777095	344.380730	79.736324	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	229,027	1,425,684	452,302	1,364,500	52,807	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.604562	0.816838	2.778951	64.954539	2.588578	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
		22.00	23.00	23.01	23.02	23.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	20,400				22.00
23.00	02300	PARAMED ED PRGM		0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			100		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				100	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY					23.04
23.05	02305	PARAMED ED PRGM-HIM					23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,907	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	955	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	49	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	648	0	0	0	41.00
43.00	04300	NURSERY	518	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,085	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	162	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113	0	100	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	130	0	0	100	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	696	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	631	0	0	0	70.00
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	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,506	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE		0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,400	0	100	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
			22.00	23.00	23.01	23.02	23.03	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,889,353	0	491,195	69,884	453,299	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	141.634951	0.000000	4,911.950000	698.840000	4,532.990000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,512	0	52,263	10,951	14,938	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.485882	0.000000	522.630000	109.510000	149.380000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	0	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	0.000000	0.000000	0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.04	23.05	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES			1.03
1.04	00104	CAP REL COSTS-MOB PHASE I			1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL			1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST			1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY			23.02
23.03	02303	PARAMED ED PRGM-PHARMACY			23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	100		23.04
23.05	02305	PARAMED ED PRGM-HIM		162,760	23.05
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	117,133	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,141	31.00
40.00	04000	SUBPROVIDER - IPF	0	7,490	40.00
41.00	04100	SUBPROVIDER - IRF	0	11,290	41.00
43.00	04300	NURSERY	0	253	43.00
44.00	04400	SKILLED NURSING FACILITY	0	12,777	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	100	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	162,760	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description			PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.04	23.05	
193.02	19302	UNUSED SPACE	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	193.03
193.04	19304	RENTED SPACE	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	193.05
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)	209,808	295,466	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,098.080000	1.815348	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,425	22,773	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	114.250000	0.139918	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

			Title XVIII		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	70,078,449		70,078,449	6,431	70,084,880	30.00
31.00	03100	INTENSIVE CARE UNIT	10,881,694		10,881,694	30,838	10,912,532	31.00
40.00	04000	SUBPROVIDER - IPF	3,359,848		3,359,848	743	3,360,591	40.00
41.00	04100	SUBPROVIDER - IRF	4,725,715		4,725,715	6,156	4,731,871	41.00
43.00	04300	NURSERY	857,687		857,687	0	857,687	43.00
44.00	04400	SKILLED NURSING FACILITY	4,967,117		4,967,117	0	4,967,117	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,653,352		30,653,352	17,212	30,670,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,139,956		2,139,956	0	2,139,956	52.00
53.00	05300	ANESTHESIOLOGY	1,191,881		1,191,881	0	1,191,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,974,355		9,974,355	0	9,974,355	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,983,399		3,983,399	0	3,983,399	55.00
57.00	05700	CT SCAN	1,799,628		1,799,628	0	1,799,628	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,372,287		1,372,287	0	1,372,287	58.00
60.00	06000	LABORATORY	12,936,243		12,936,243	0	12,936,243	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,880,919		1,880,919	0	1,880,919	62.00
65.00	06500	RESPIRATORY THERAPY	4,241,764	0	4,241,764	5,143	4,246,907	65.00
66.00	06600	PHYSICAL THERAPY	2,457,326	0	2,457,326	0	2,457,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,441,561	0	1,441,561	0	1,441,561	67.00
68.00	06800	SPEECH PATHOLOGY	472,426	0	472,426	0	472,426	68.00
69.00	06900	ELECTROCARDIOLOGY	6,151,807		6,151,807	7,791	6,159,598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	978,964		978,964	3,044	982,008	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,149,330		17,149,330	0	17,149,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,309,357		22,309,357	0	22,309,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,787,872		34,787,872	0	34,787,872	73.00
74.00	07400	RENAL DIALYSIS	1,283,391		1,283,391	0	1,283,391	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,361,090		1,361,090	0	1,361,090	88.00
90.00	09000	CLINIC	864,723		864,723	0	864,723	90.00
90.01	09001	OUTPATIENT INFUSION	1,150,587		1,150,587	0	1,150,587	90.01
91.00	09100	EMERGENCY	13,228,974		13,228,974	99,065	13,328,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,311,782		7,311,782	0	7,311,782	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,792,763		6,792,763	0	6,792,763	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,654,713		3,654,713		3,654,713	116.00
200.00		Subtotal (see instructions)	286,440,960	0	286,440,960	176,423	286,617,383	200.00
201.00		Less Observation Beds	7,311,782		7,311,782		7,311,782	201.00
202.00		Total (see instructions)	279,129,178	0	279,129,178	176,423	279,305,601	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
12/30/2020 1:42 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	130,864,641		130,864,641			30.00
31.00	03100	INTENSIVE CARE UNIT	50,040,685		50,040,685			31.00
40.00	04000	SUBPROVIDER - IPF	7,925,088		7,925,088			40.00
41.00	04100	SUBPROVIDER - IRF	7,085,925		7,085,925			41.00
43.00	04300	NURSERY	3,364,382		3,364,382			43.00
44.00	04400	SKILLED NURSING FACILITY	6,219,355		6,219,355			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,191,874	104,000,300	151,192,174	0.202744	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,447,424	2,008,762	10,456,186	0.204659	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	15,245,360	26,024,877	41,270,237	0.028880	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,945,240	46,764,884	63,710,124	0.156558	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,009,452	22,990,096	23,999,548	0.165978	0.000000	55.00
57.00	05700	CT SCAN	35,288,347	56,920,618	92,208,965	0.019517	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,600,272	15,209,032	24,809,304	0.055313	0.000000	58.00
60.00	06000	LABORATORY	71,644,373	76,731,644	148,376,017	0.087186	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,461,556	2,802,453	8,264,009	0.227604	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	20,491,617	4,497,527	24,989,144	0.169744	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,954,761	641,159	5,595,920	0.439128	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,243,061	233,914	4,476,975	0.321994	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,405,334	382,912	1,788,246	0.264184	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	50,080,730	64,834,459	114,915,189	0.053533	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	561,443	2,803,858	3,365,301	0.290899	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,052,677	56,680,521	98,733,198	0.173694	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,585,914	67,401,742	116,987,656	0.190698	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,539,863	142,762,171	255,302,034	0.136262	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,309,080	0	3,309,080	0.387839	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,578,954	1,578,954			88.00
90.00	09000	CLINIC	810	868,165	868,975	0.995107	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	44,224	3,739,151	3,783,375	0.304117	0.000000	90.01
91.00	09100	EMERGENCY	18,873,199	34,361,894	53,235,093	0.248501	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,495,596	19,486,156	22,981,752	0.318156	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	7,244,203	7,244,203			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	56,915	5,387,837	5,444,752			116.00
200.00		Subtotal (see instructions)	728,029,198	766,357,289	1,494,386,487			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	728,029,198	766,357,289	1,494,386,487			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet C Part I Date/Time Prepared: 12/30/2020 1:42 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.202858		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204659		52.00
53.00	05300	ANESTHESIOLOGY	0.028880		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156558		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165978		55.00
57.00	05700	CT SCAN	0.019517		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.055313		58.00
60.00	06000	LABORATORY	0.087186		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604		62.00
65.00	06500	RESPIRATORY THERAPY	0.169950		65.00
66.00	06600	PHYSICAL THERAPY	0.439128		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.321994		67.00
68.00	06800	SPEECH PATHOLOGY	0.264184		68.00
69.00	06900	ELECTROCARDIOLOGY	0.053601		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.291804		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190698		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136262		73.00
74.00	07400	RENAL DIALYSIS	0.387839		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.995107		90.00
90.01	09001	OUTPATIENT INFUSION	0.304117		90.01
91.00	09100	EMERGENCY	0.250362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318156		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

			Title XIX		Hospital		Cost	
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	70,078,449		70,078,449	6,431	70,084,880	30.00
31.00	03100	INTENSIVE CARE UNIT	10,881,694		10,881,694	30,838	10,912,532	31.00
40.00	04000	SUBPROVIDER - IPF	3,359,848		3,359,848	743	3,360,591	40.00
41.00	04100	SUBPROVIDER - IRF	4,725,715		4,725,715	6,156	4,731,871	41.00
43.00	04300	NURSERY	857,687		857,687	0	857,687	43.00
44.00	04400	SKILLED NURSING FACILITY	4,967,117		4,967,117	0	4,967,117	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,653,352		30,653,352	17,212	30,670,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,139,956		2,139,956	0	2,139,956	52.00
53.00	05300	ANESTHESIOLOGY	1,191,881		1,191,881	0	1,191,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,974,355		9,974,355	0	9,974,355	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,983,399		3,983,399	0	3,983,399	55.00
57.00	05700	CT SCAN	1,799,628		1,799,628	0	1,799,628	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,372,287		1,372,287	0	1,372,287	58.00
60.00	06000	LABORATORY	12,936,243		12,936,243	0	12,936,243	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,880,919		1,880,919	0	1,880,919	62.00
65.00	06500	RESPIRATORY THERAPY	4,241,764	0	4,241,764	5,143	4,246,907	65.00
66.00	06600	PHYSICAL THERAPY	2,457,326	0	2,457,326	0	2,457,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,441,561	0	1,441,561	0	1,441,561	67.00
68.00	06800	SPEECH PATHOLOGY	472,426	0	472,426	0	472,426	68.00
69.00	06900	ELECTROCARDIOLOGY	6,151,807		6,151,807	7,791	6,159,598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	978,964		978,964	3,044	982,008	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,149,330		17,149,330	0	17,149,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,309,357		22,309,357	0	22,309,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,787,872		34,787,872	0	34,787,872	73.00
74.00	07400	RENAL DIALYSIS	1,283,391		1,283,391	0	1,283,391	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,361,090		1,361,090	0	1,361,090	88.00
90.00	09000	CLINIC	864,723		864,723	0	864,723	90.00
90.01	09001	OUTPATIENT INFUSION	1,150,587		1,150,587	0	1,150,587	90.01
91.00	09100	EMERGENCY	13,228,974		13,228,974	99,065	13,328,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,311,782		7,311,782	0	7,311,782	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,792,763		6,792,763	0	6,792,763	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,654,713		3,654,713		3,654,713	116.00
200.00		Subtotal (see instructions)	286,440,960	0	286,440,960	176,423	286,617,383	200.00
201.00		Less Observation Beds	7,311,782		7,311,782		7,311,782	201.00
202.00		Total (see instructions)	279,129,178	0	279,129,178	176,423	279,305,601	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

			Title XIX		Hospital	Cost	
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	130,864,641		130,864,641		30.00
31.00	03100	INTENSIVE CARE UNIT	50,040,685		50,040,685		31.00
40.00	04000	SUBPROVIDER - IPF	7,925,088		7,925,088		40.00
41.00	04100	SUBPROVIDER - IRF	7,085,925		7,085,925		41.00
43.00	04300	NURSERY	3,364,382		3,364,382		43.00
44.00	04400	SKILLED NURSING FACILITY	6,219,355		6,219,355		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,191,874	104,000,300	151,192,174	0.202744	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,447,424	2,008,762	10,456,186	0.204659	0.000000
53.00	05300	ANESTHESIOLOGY	15,245,360	26,024,877	41,270,237	0.028880	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,945,240	46,764,884	63,710,124	0.156558	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,009,452	22,990,096	23,999,548	0.165978	0.000000
57.00	05700	CT SCAN	35,288,347	56,920,618	92,208,965	0.019517	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,600,272	15,209,032	24,809,304	0.055313	0.000000
60.00	06000	LABORATORY	71,644,373	76,731,644	148,376,017	0.087186	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,461,556	2,802,453	8,264,009	0.227604	0.000000
65.00	06500	RESPIRATORY THERAPY	20,491,617	4,497,527	24,989,144	0.169744	0.000000
66.00	06600	PHYSICAL THERAPY	4,954,761	641,159	5,595,920	0.439128	0.000000
67.00	06700	OCCUPATIONAL THERAPY	4,243,061	233,914	4,476,975	0.321994	0.000000
68.00	06800	SPEECH PATHOLOGY	1,405,334	382,912	1,788,246	0.264184	0.000000
69.00	06900	ELECTROCARDIOLOGY	50,080,730	64,834,459	114,915,189	0.053533	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	561,443	2,803,858	3,365,301	0.290899	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,052,677	56,680,521	98,733,198	0.173694	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,585,914	67,401,742	116,987,656	0.190698	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	112,539,863	142,762,171	255,302,034	0.136262	0.000000
74.00	07400	RENAL DIALYSIS	3,309,080	0	3,309,080	0.387839	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,578,954	1,578,954	0.862020	0.000000
90.00	09000	CLINIC	810	868,165	868,975	0.995107	0.000000
90.01	09001	OUTPATIENT INFUSION	44,224	3,739,151	3,783,375	0.304117	0.000000
91.00	09100	EMERGENCY	18,873,199	34,361,894	53,235,093	0.248501	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,495,596	19,486,156	22,981,752	0.318156	0.000000
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	7,244,203	7,244,203		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	56,915	5,387,837	5,444,752		116.00
200.00		Subtotal (see instructions)	728,029,198	766,357,289	1,494,386,487		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	728,029,198	766,357,289	1,494,386,487		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet C Part I Date/Time Prepared: 12/30/2020 1:42 pm
				Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		30.00		
31.00	03100	INTENSIVE CARE UNIT		31.00		
40.00	04000	SUBPROVIDER - IPF		40.00		
41.00	04100	SUBPROVIDER - IRF		41.00		
43.00	04300	NURSERY		43.00		
44.00	04400	SKILLED NURSING FACILITY		44.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	50.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00		
53.00	05300	ANESTHESIOLOGY	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00		
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00		
57.00	05700	CT SCAN	0.000000	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00		
60.00	06000	LABORATORY	0.000000	60.00		
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00		
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	0.000000	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00		
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00		
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	0.000000	74.00		
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00		
90.00	09000	CLINIC	0.000000	90.00		
90.01	09001	OUTPATIENT INFUSION	0.000000	90.01		
91.00	09100	EMERGENCY	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00		
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		101.00		
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		113.00		
116.00	11600	HOSPICE		116.00		
200.00		Subtotal (see instructions)		200.00		
201.00		Less Observation Beds		201.00		
202.00		Total (see instructions)		202.00		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
12/30/2020 1:42 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,450,119	0	6,450,119	53,476	120.62	30.00
31.00	INTENSIVE CARE UNIT	832,825		832,825	5,453	152.73	31.00
40.00	SUBPROVIDER - IPF	284,329	0	284,329	3,062	92.86	40.00
41.00	SUBPROVIDER - IRF	331,264	0	331,264	4,622	71.67	41.00
43.00	NURSERY	101,726		101,726	1,903	53.46	43.00
44.00	SKILLED NURSING FACILITY	407,927		407,927	5,322	76.65	44.00
200.00	Total (lines 30 through 199)	8,408,190		8,408,190	73,838		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	22,668	2,734,214				30.00
31.00	INTENSIVE CARE UNIT	2,546	388,851				31.00
40.00	SUBPROVIDER - IPF	314	29,158				40.00
41.00	SUBPROVIDER - IRF	2,942	210,853				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,582	274,560				44.00
200.00	Total (lines 30 through 199)	32,052	3,637,636				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
12/30/2020 1:42 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,046,271	151,192,174	0.033377	23,011,214	768,045	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,488	10,456,186	0.013818	61,993	857	52.00
53.00	05300	ANESTHESIOLOGY	149,576	41,270,237	0.003624	7,023,955	25,455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,486	63,710,124	0.022955	9,098,170	208,848	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	892,419	23,999,548	0.037185	897,567	33,376	55.00
57.00	05700	CT SCAN	396,331	92,208,965	0.004298	17,651,254	75,865	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132,249	24,809,304	0.005331	4,721,128	25,168	58.00
60.00	06000	LABORATORY	995,594	148,376,017	0.006710	35,044,233	235,147	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,999	8,264,009	0.009680	2,838,672	27,478	62.00
65.00	06500	RESPIRATORY THERAPY	242,545	24,989,144	0.009706	10,964,920	106,426	65.00
66.00	06600	PHYSICAL THERAPY	135,482	5,595,920	0.024211	1,396,041	33,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,422	4,476,975	0.016400	942,282	15,453	67.00
68.00	06800	SPEECH PATHOLOGY	25,082	1,788,246	0.014026	491,726	6,897	68.00
69.00	06900	ELECTROCARDIOLOGY	1,144,925	114,915,189	0.009963	24,957,088	248,647	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	164,746	3,365,301	0.048954	289,081	14,152	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	707,655	98,733,198	0.007167	24,996,903	179,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	961,157	116,987,656	0.008216	20,851,705	171,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,493,529	255,302,034	0.005850	52,132,290	304,974	73.00
74.00	07400	RENAL DIALYSIS	47,414	3,309,080	0.014328	1,344,901	19,270	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	87,324	1,578,954	0.055305	0	0	88.00
90.00	09000	CLINIC	98,085	868,975	0.112874	810	91	90.00
90.01	09001	OUTPATIENT INFUSION	94,024	3,783,375	0.024852	39,895	991	90.01
91.00	09100	EMERGENCY	931,832	53,235,093	0.017504	8,971,522	157,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	672,925	22,981,752	0.029281	1,269,235	37,164	92.00
200.00		Total (lines 50 through 199)	16,179,560	1,276,197,456		248,996,585	2,695,613	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 12/30/2020 1:42 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	5,664,030	0	212,638	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	499,008	0	23,855	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	110,202	0	13,597	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	35,816	0	20,495	0	41.00		
43.00	04300	NURSERY	0	92,638	0	459	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	30,650	0	23,195	0	44.00		
200.00		Total (lines 30 through 199)	0	6,432,344	0	294,239	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	5,876,668	53,476	109.89	22,668	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	522,863	5,453	95.89	2,546	31.00		
40.00	04000	SUBPROVIDER - IPF	0	123,799	3,062	40.43	314	40.00		
41.00	04100	SUBPROVIDER - IRF	0	56,311	4,622	12.18	2,942	41.00		
43.00	04300	NURSERY	0	93,097	1,903	48.92	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	53,845	5,322	10.12	3,582	44.00		
200.00		Total (lines 30 through 199)	0	6,726,583	73,838		32,052	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	2,490,987							30.00
31.00	03100	INTENSIVE CARE UNIT	244,136							31.00
40.00	04000	SUBPROVIDER - IPF	12,695							40.00
41.00	04100	SUBPROVIDER - IRF	35,834							41.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	36,250							44.00
200.00		Total (lines 30 through 199)	2,819,902							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description		Title XVIII		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	190,098	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	270,683	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	491,195	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	69,884	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,755	209,808	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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	0	0	0	453,299	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	275,849	1,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	590,916	22,184	92.00
200.00		Total (lines 50 through 199)	0	0	1,330,301	1,247,597	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 12/30/2020 1:42 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	190,098	190,098	151,192,174	0.001257	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	270,683	270,683	10,456,186	0.025887	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	41,270,237	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	491,195	491,195	63,710,124	0.007710	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	23,999,548	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	92,208,965	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	24,809,304	0.000000	58.00
60.00	06000	LABORATORY	0	69,884	69,884	148,376,017	0.000471	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,264,009	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	212,563	212,563	24,989,144	0.008506	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,595,920	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,476,975	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,788,246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	114,915,189	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,365,301	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	98,733,198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	116,987,656	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	453,299	453,299	255,302,034	0.001776	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,309,080	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,578,954	0.000000	88.00
90.00	09000	CLINIC	0	0	0	868,975	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,783,375	0.000000	90.01
91.00	09100	EMERGENCY	0	277,076	277,076	53,235,093	0.005205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	613,100	613,100	22,981,752	0.026678	92.00
200.00		Total (lines 50 through 199)	0	2,577,898	2,577,898	1,276,197,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
12/30/2020 1:42 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.001257	23,011,214	28,925	34,847,558	43,803	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.025887	61,993	1,605	22,207	575	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	7,023,955	0	8,245,617	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007710	9,098,170	70,147	13,181,402	101,629	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	897,567	0	17,185,209	0	55.00
57.00	05700	CT SCAN	0.000000	17,651,254	0	16,605,780	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,721,128	0	4,530,894	0	58.00
60.00	06000	LABORATORY	0.000471	35,044,233	16,506	11,008,187	5,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,838,672	0	650,784	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.008506	10,964,920	93,268	2,037,936	17,335	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,396,041	0	25,512	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	942,282	0	18,716	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	491,726	0	9,913	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	24,957,088	0	29,625,269	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	289,081	0	792,317	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	24,996,903	0	25,275,153	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	20,851,705	0	23,400,953	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001776	52,132,290	92,587	55,489,232	98,549	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,344,901	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	810	0	402,279	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	39,895	0	1,861,579	0	90.01
91.00	09100	EMERGENCY	0.005205	8,971,522	46,697	7,255,518	37,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.026678	1,269,235	33,861	7,239,605	193,138	92.00
200.00		Total (lines 50 through 199)		248,996,585	383,596	259,711,620	497,979	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
12/30/2020 1:42 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	0.202744	34,847,558	0	0	7,065,133	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204659	22,207	0	0	4,545	52.00
53.00	05300	ANESTHESIOLOGY	0.028880	8,245,617	0	0	238,133	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156558	13,181,402	0	0	2,063,654	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165978	17,185,209	0	0	2,852,367	55.00
57.00	05700	CT SCAN	0.019517	16,605,780	0	0	324,095	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.055313	4,530,894	0	0	250,617	58.00
60.00	06000	LABORATORY	0.087186	11,008,187	0	0	959,760	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	650,784	0	0	148,121	62.00
65.00	06500	RESPIRATORY THERAPY	0.169744	2,037,936	0	0	345,927	65.00
66.00	06600	PHYSICAL THERAPY	0.439128	25,512	0	0	11,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.321994	18,716	0	0	6,026	67.00
68.00	06800	SPEECH PATHOLOGY	0.264184	9,913	0	0	2,619	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053533	29,625,269	0	0	1,585,930	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.290899	792,317	0	0	230,484	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	25,275,153	0	0	4,390,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190698	23,400,953	367,258	0	4,462,515	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136262	55,489,232	0	0	7,561,074	73.00
74.00	07400	RENAL DIALYSIS	0.387839	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.995107	402,279	0	0	400,311	90.00
90.01	09001	OUTPATIENT INFUSION	0.304117	1,861,579	0	0	566,138	90.01
91.00	09100	EMERGENCY	0.248501	7,255,518	0	0	1,803,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	7,239,605	0	0	2,303,324	92.00
200.00		Subtotal (see instructions)		259,711,620	367,258	0	37,575,121	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		259,711,620	367,258	0	37,575,121	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
12/30/2020 1:42 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,035	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	70,035	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	70,035	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-S015

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,046,271	151,192,174	0.033377	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	144,488	10,456,186	0.013818	0	0	52.00
53.00	05300 ANESTHESIOLOGY	149,576	41,270,237	0.003624	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,462,486	63,710,124	0.022955	12,566	288	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	892,419	23,999,548	0.037185	0	0	55.00
57.00	05700 CT SCAN	396,331	92,208,965	0.004298	14,017	60	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	132,249	24,809,304	0.005331	19,237	103	58.00
60.00	06000 LABORATORY	995,594	148,376,017	0.006710	83,255	559	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	79,999	8,264,009	0.009680	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	242,545	24,989,144	0.009706	4,330	42	65.00
66.00	06600 PHYSICAL THERAPY	135,482	5,595,920	0.024211	1,611	39	66.00
67.00	06700 OCCUPATIONAL THERAPY	73,422	4,476,975	0.016400	671	11	67.00
68.00	06800 SPEECH PATHOLOGY	25,082	1,788,246	0.014026	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,144,925	114,915,189	0.009963	26,722	266	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	164,746	3,365,301	0.048954	1,074	53	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	707,655	98,733,198	0.007167	1,481	11	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	961,157	116,987,656	0.008216	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,493,529	255,302,034	0.005850	173,050	1,012	73.00
74.00	07400 RENAL DIALYSIS	47,414	3,309,080	0.014328	5,000	72	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	87,324	1,578,954	0.055305	0	0	88.00
90.00	09000 CLINIC	98,085	868,975	0.112874	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	94,024	3,783,375	0.024852	0	0	90.01
91.00	09100 EMERGENCY	931,832	53,235,093	0.017504	40,111	702	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	22,981,752	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	15,506,635	1,276,197,456		383,125	3,218	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 12/30/2020 1:42 pm	
				Title XVIII		Subprovider - IPF		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	190,098	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	270,683	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	491,195	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
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	69,884	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	2,755	0	209,808	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	453,299	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	275,849	0	1,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	739,385	0	1,225,413	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 12/30/2020 1:42 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	190,098	190,098	151,192,174	0.001257	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	270,683	270,683	10,456,186	0.025887	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	41,270,237	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	491,195	491,195	63,710,124	0.007710	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	23,999,548	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	92,208,965	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	24,809,304	0.000000	58.00
60.00	06000	LABORATORY	0	69,884	69,884	148,376,017	0.000471	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,264,009	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	212,563	212,563	24,989,144	0.008506	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,595,920	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,476,975	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,788,246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	114,915,189	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,365,301	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	98,733,198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	116,987,656	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	453,299	453,299	255,302,034	0.001776	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,309,080	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,578,954	0.000000	88.00
90.00	09000	CLINIC	0	0	0	868,975	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,783,375	0.000000	90.01
91.00	09100	EMERGENCY	0	277,076	277,076	53,235,093	0.005205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	22,981,752	0.000000	92.00
200.00		Total (lines 50 through 199)	0	1,964,798	1,964,798	1,276,197,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 12/30/2020 1:42 pm	
				Title XVIII		Subprovider - IPF		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	0.001257	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.025887	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007710	12,566	97	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	14,017	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	19,237	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000471	83,255	39	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.008506	4,330	37	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,611	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	671	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	26,722	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,074	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,481	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	0.001776	173,050	307	240	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	5,000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.005205	40,111	209	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		383,125	689	240	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-S015

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
12/30/2020 1:42 pm

Title XVIII

Subprovider -
IPF

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	0.202744	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.204659	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.028880	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156558	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.165978	0	0	0	0 55.00
57.00	05700 CT SCAN	0.019517	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.055313	0	0	0	0 58.00
60.00	06000 LABORATORY	0.087186	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.169744	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.439128	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.321994	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.264184	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.053533	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.290899	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.190698	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136262	240	0	998	33 73.00
74.00	07400 RENAL DIALYSIS	0.387839	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC					88.00
90.00	09000 CLINIC	0.995107	0	0	0	0 90.00
90.01	09001 OUTPATIENT INFUSION	0.304117	0	0	0	0 90.01
91.00	09100 EMERGENCY	0.248501	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	0	0	0	0 92.00
200.00	Subtotal (see instructions)		240	0	998	33 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		240	0	998	33 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 12/30/2020 1:42 pm
			Title XVIII		Subprovider - IPF	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	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00	
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	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00	
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	136	73.00	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			88.00	
90.00	09000	CLINIC	0	0	90.00	
90.01	09001	OUTPATIENT INFUSION	0	0	90.01	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00	
200.00		Subtotal (see instructions)	0	136	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	0	136	202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 12/30/2020 1:42 pm		
				Component CCN: 14-T015				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,046,271	151,192,174	0.033377	95,308	3,181	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,488	10,456,186	0.013818	0	0	52.00
53.00	05300	ANESTHESIOLOGY	149,576	41,270,237	0.003624	23,971	87	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,486	63,710,124	0.022955	137,548	3,157	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	892,419	23,999,548	0.037185	17,078	635	55.00
57.00	05700	CT SCAN	396,331	92,208,965	0.004298	90,118	387	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132,249	24,809,304	0.005331	44,259	236	58.00
60.00	06000	LABORATORY	995,594	148,376,017	0.006710	913,780	6,131	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,999	8,264,009	0.009680	56,159	544	62.00
65.00	06500	RESPIRATORY THERAPY	242,545	24,989,144	0.009706	225,600	2,190	65.00
66.00	06600	PHYSICAL THERAPY	135,482	5,595,920	0.024211	1,132,519	27,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,422	4,476,975	0.016400	1,120,031	18,369	67.00
68.00	06800	SPEECH PATHOLOGY	25,082	1,788,246	0.014026	352,973	4,951	68.00
69.00	06900	ELECTROCARDIOLOGY	1,144,925	114,915,189	0.009963	66,357	661	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	164,746	3,365,301	0.048954	4,638	227	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	707,655	98,733,198	0.007167	159,061	1,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	961,157	116,987,656	0.008216	72,916	599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,493,529	255,302,034	0.005850	1,085,362	6,349	73.00
74.00	07400	RENAL DIALYSIS	47,414	3,309,080	0.014328	74,588	1,069	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	87,324	1,578,954	0.055305	0	0	88.00
90.00	09000	CLINIC	98,085	868,975	0.112874	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	94,024	3,783,375	0.024852	0	0	90.01
91.00	09100	EMERGENCY	931,832	53,235,093	0.017504	36	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,981,752	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	15,506,635	1,276,197,456		5,672,302	77,333	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015
Component CCN: 14-T015

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
12/30/2020 1:42 pm

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	190,098	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	270,683	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	491,195	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	69,884	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	2,755	0	209,808	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	453,299	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	275,849	0	1,227	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	739,385	0	1,225,413	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 12/30/2020 1:42 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	190,098	190,098	151,192,174	0.001257	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	270,683	270,683	10,456,186	0.025887	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	41,270,237	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	491,195	491,195	63,710,124	0.007710	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	23,999,548	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	92,208,965	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	24,809,304	0.000000	58.00
60.00	06000	LABORATORY	0	69,884	69,884	148,376,017	0.000471	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,264,009	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	212,563	212,563	24,989,144	0.008506	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,595,920	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,476,975	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,788,246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	114,915,189	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,365,301	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	98,733,198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	116,987,656	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	453,299	453,299	255,302,034	0.001776	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,309,080	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,578,954	0.000000	88.00
90.00	09000	CLINIC	0	0	0	868,975	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,783,375	0.000000	90.01
91.00	09100	EMERGENCY	0	277,076	277,076	53,235,093	0.005205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	22,981,752	0.000000	92.00
200.00		Total (lines 50 through 199)	0	1,964,798	1,964,798	1,276,197,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015

Component CCN: 14-T015

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
12/30/2020 1:42 pm

				Title XVIII		Subprovider - IRF	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	0.001257	95,308	120	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.025887	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,971	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007710	137,548	1,060	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	17,078	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	90,118	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	44,259	0	0	0	58.00
60.00	06000	LABORATORY	0.000471	913,780	430	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	56,159	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.008506	225,600	1,919	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,132,519	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,120,031	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	352,973	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	66,357	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,638	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	159,061	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72,916	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001776	1,085,362	1,928	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74,588	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.005205	36	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,672,302	5,457	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 12/30/2020 1:42 pm	
				Title XVIII		Subprovider - IRF		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	0.202744	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204659	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028880	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156558	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165978	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.019517	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.055313	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.087186	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.169744	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.439128	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.321994	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.264184	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053533	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.290899	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190698	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136262	0	0	0	5,082	0	73.00
74.00	07400	RENAL DIALYSIS	0.387839	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC	0.995107	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.304117	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.248501	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	5,082	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	5,082	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 12/30/2020 1:42 pm	
			Title XVIII		Subprovider - IRF		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				
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				
53.00	05300	ANESTHESIOLOGY	0	0				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				
57.00	05700	CT SCAN	0	0				
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				
60.00	06000	LABORATORY	0	0				
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				
65.00	06500	RESPIRATORY THERAPY	0	0				
66.00	06600	PHYSICAL THERAPY	0	0				
67.00	06700	OCCUPATIONAL THERAPY	0	0				
68.00	06800	SPEECH PATHOLOGY	0	0				
69.00	06900	ELECTROCARDIOLOGY	0	0				
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS	0	692				
74.00	07400	RENAL DIALYSIS	0	0				
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						
90.00	09000	CLINIC	0	0				
90.01	09001	OUTPATIENT INFUSION	0	0				
91.00	09100	EMERGENCY	0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				
200.00		Subtotal (see instructions)	0	692				
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					
202.00		Net Charges (line 200 - line 201)	0	692				

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-5643

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
12/30/2020 1:42 pm

Title XVIII

Skilled Nursing
Facility

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	0.202744	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.204659	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.028880	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156558	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.165978	0	0	0	0 55.00
57.00	05700 CT SCAN	0.019517	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.055313	0	0	0	0 58.00
60.00	06000 LABORATORY	0.087186	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.169744	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.439128	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.321994	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.264184	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.053533	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.290899	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.190698	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136262	0	0	24,142	0 73.00
74.00	07400 RENAL DIALYSIS	0.387839	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC					88.00
90.00	09000 CLINIC	0.995107	0	0	0	0 90.00
90.01	09001 OUTPATIENT INFUSION	0.304117	0	0	0	0 90.01
91.00	09100 EMERGENCY	0.248501	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	24,142	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	24,142	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-5643

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
12/30/2020 1:42 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Costs		
		Cost	Cost	
		Reimbursed	Reimbursed	
		Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)	
		6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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	3,290	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	3,290	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	3,290	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		53,476	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		53,476	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)		47,897	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		22,668	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		70,084,880	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)		70,084,880	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)		70,084,880	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)		1,310.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		29,708,454	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)		29,708,454	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
12/30/2020 1:42 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10,912,532	5,453	2,001.20	2,546	5,095,055
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					33,702,265
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					68,505,774
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,858,188
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,079,209
52.00	Total Program excludable cost (sum of lines 50 and 51)					8,937,397
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					59,568,377
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					5,579
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,310.59
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,311,782

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
12/30/2020 1:42 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	6,450,119	70,084,880	0.092033	7,311,782	672,925	90.00
91.00 Nursing School cost	5,664,030	70,084,880	0.080817	7,311,782	590,916	91.00
92.00 Allied health cost	212,638	70,084,880	0.003034	7,311,782	22,184	92.00
93.00 All other Medical Education	0	70,084,880	0.000000	7,311,782	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Subprovider - IPF	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)		3,062	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,062	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,062	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		314	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,360,591	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)		3,360,591	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,360,591	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)		1,097.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		344,621	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)		344,621	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:

Worksheet D-1

Component CCN: 14-S015

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					49,786	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					394,407	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)					41,853	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,907	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					45,760	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					348,647	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)					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: 14-0015 Component CCN: 14-S015		Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII		Subprovider - IPF	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	284,329	3,360,591	0.084607	0	0	90.00
91.00 Nursing School cost	110,202	3,360,591	0.032792	0	0	91.00
92.00 Allied health cost	13,597	3,360,591	0.004046	0	0	92.00
93.00 All other Medical Education	0	3,360,591	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Subprovider - IRF	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)		4,622	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,622	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)		4,622	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,942	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,731,871	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)		4,731,871	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)		4,731,871	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)		1,023.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,011,931	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,011,931	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 pm	
				Title XVIII		Subprovider - IRF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,353,882	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,365,813	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)					246,687	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					82,790	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					329,477	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,036,336	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)					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: 14-0015 Component CCN: 14-T015		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII		Subprovider - IRF		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	331,264	4,731,871	0.070007	0	0	90.00
91.00	Nursing School cost	35,816	4,731,871	0.007569	0	0	91.00
92.00	Allied health cost	20,495	4,731,871	0.004331	0	0	92.00
93.00	All other Medical Education	0	4,731,871	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 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)		5,322	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,322	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)		5,322	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,582	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,967,117	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)		4,967,117	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)		4,967,117	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: 14-0015 Component CCN: 14-5643	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 12/30/2020 1:42 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)				4,967,117	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				933.32	71.00
72.00 Program routine service cost (line 9 x line 71)				3,343,152	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)				3,343,152	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)				3,343,152	83.00
84.00 Program inpatient ancillary services (see instructions)				1,228,914	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)				4,572,066	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: 14-0015

Period:

Worksheet D-1

Component CCN: 14-5643

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 12/30/2020 1:42 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		64,126,198		30.00
31.00	03100	INTENSIVE CARE UNIT		23,316,497		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202858	23,011,214	4,668,009	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.204659	61,993	12,687	52.00
53.00	05300	ANESTHESIOLOGY	0.028880	7,023,955	202,852	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156558	9,098,170	1,424,391	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.165978	897,567	148,976	55.00
57.00	05700	CT SCAN	0.019517	17,651,254	344,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.055313	4,721,128	261,140	58.00
60.00	06000	LABORATORY	0.087186	35,044,233	3,055,366	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	2,838,672	646,093	62.00
65.00	06500	RESPIRATORY THERAPY	0.169950	10,964,920	1,863,488	65.00
66.00	06600	PHYSICAL THERAPY	0.439128	1,396,041	613,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.321994	942,282	303,409	67.00
68.00	06800	SPEECH PATHOLOGY	0.264184	491,726	129,906	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053601	24,957,088	1,337,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.291804	289,081	84,355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	24,996,903	4,341,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190698	20,851,705	3,976,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136262	52,132,290	7,103,650	73.00
74.00	07400	RENAL DIALYSIS	0.387839	1,344,901	521,605	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.995107	810	806	90.00
90.01	09001	OUTPATIENT INFUSION	0.304117	39,895	12,133	90.01
91.00	09100	EMERGENCY	0.250362	8,971,522	2,246,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	1,269,235	403,815	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		248,996,585	33,702,265	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)		248,996,585		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII	Subprovider - IPF	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
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		811,608		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.202858	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.204659	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.028880	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156558	12,566	1,967	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.165978	0	0	55.00
57.00	05700 CT SCAN	0.019517	14,017	274	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.055313	19,237	1,064	58.00
60.00	06000 LABORATORY	0.087186	83,255	7,259	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.169950	4,330	736	65.00
66.00	06600 PHYSICAL THERAPY	0.439128	1,611	707	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.321994	671	216	67.00
68.00	06800 SPEECH PATHOLOGY	0.264184	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.053601	26,722	1,432	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.291804	1,074	313	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	1,481	257	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.190698	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136262	173,050	23,580	73.00
74.00	07400 RENAL DIALYSIS	0.387839	5,000	1,939	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.995107	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.304117	0	0	90.01
91.00	09100 EMERGENCY	0.250362	40,111	10,042	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		383,125	49,786	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)		383,125		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII	Subprovider - IRF	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
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		4,597,553		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.202858	95,308	19,334	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.204659	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.028880	23,971	692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156558	137,548	21,534	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.165978	17,078	2,835	55.00
57.00	05700 CT SCAN	0.019517	90,118	1,759	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.055313	44,259	2,448	58.00
60.00	06000 LABORATORY	0.087186	913,780	79,669	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	56,159	12,782	62.00
65.00	06500 RESPIRATORY THERAPY	0.169950	225,600	38,341	65.00
66.00	06600 PHYSICAL THERAPY	0.439128	1,132,519	497,321	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.321994	1,120,031	360,643	67.00
68.00	06800 SPEECH PATHOLOGY	0.264184	352,973	93,250	68.00
69.00	06900 ELECTROCARDIOLOGY	0.053601	66,357	3,557	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.291804	4,638	1,353	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	159,061	27,628	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.190698	72,916	13,905	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136262	1,085,362	147,894	73.00
74.00	07400 RENAL DIALYSIS	0.387839	74,588	28,928	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.995107	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.304117	0	0	90.01
91.00	09100 EMERGENCY	0.250362	36	9	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,672,302	1,353,882	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)		5,672,302		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 12/30/2020 1:42 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
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.202858	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.204659	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.028880	703	20	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156558	158,612	24,832	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.165978	0	0	55.00
57.00	05700 CT SCAN	0.019517	4,447	87	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.055313	0	0	58.00
60.00	06000 LABORATORY	0.087186	1,147,716	100,065	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.227604	48,464	11,031	62.00
65.00	06500 RESPIRATORY THERAPY	0.169950	620,021	105,373	65.00
66.00	06600 PHYSICAL THERAPY	0.439128	695,177	305,272	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.321994	715,065	230,247	67.00
68.00	06800 SPEECH PATHOLOGY	0.264184	41,990	11,093	68.00
69.00	06900 ELECTROCARDIOLOGY	0.053601	42,344	2,270	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.291804	6,197	1,808	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173694	147,360	25,596	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.190698	887	169	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136262	2,843,561	387,469	73.00
74.00	07400 RENAL DIALYSIS	0.387839	60,777	23,572	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.995107	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.304117	0	0	90.01
91.00	09100 EMERGENCY	0.250362	39	10	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.318156	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,533,360	1,228,914	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)		6,533,360		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 12/30/2020 1:42 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)			50,829,558	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)			1,971,799	2.04
3.00	Managed Care Simulated Payments			12,978,937	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			254.45	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			13.16	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)			13.16	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			17.00	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)			13.16	12.00
13.00	Total allowable FTE count for the prior year.			13.16	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.			13.16	14.00
15.00	Sum of lines 12 through 14 divided by 3.			13.16	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			13.16	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.051719	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.057004	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.051719	21.00
22.00	IME payment adjustment (see instructions)			1,415,756	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			361,502	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)			3.84	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)			1,415,756	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			361,502	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			4.73	30.00
31.00	Percentage of Medicaid patient days (see instructions)			23.65	31.00
32.00	Sum of lines 30 and 31			28.38	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.63	33.00
34.00	Disproportionate share adjustment (see instructions)			1,604,943	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 12/30/2020 1:42 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	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000000000	0	0.000257435	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	2,149,736	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,149,736	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,149,736		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)		57,971,792		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		61,996,456		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			62,357,958	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			4,392,230	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).			571,607	52.00
53.00	Nursing and Allied Health Managed Care payment			284,719	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).			2,735,123	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			383,596	58.00
59.00	Total (sum of amounts on lines 49 through 58)			70,725,233	59.00
60.00	Primary payer payments			24,121	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			70,701,112	61.00
62.00	Deductibles billed to program beneficiaries			5,439,544	62.00
63.00	Coinsurance billed to program beneficiaries			259,094	63.00
64.00	Allowable bad debts (see instructions)			1,293,123	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			840,530	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,219,641	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			65,843,004	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)			0	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)			161,155	70.93
70.94	HRR adjustment amount (see instructions)			-249,066	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 12/30/2020 1:42 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)	0	0	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)		65,755,093	71.00
71.01	Sequestration adjustment (see instructions)		762,759	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		66,126,018	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-1,133,684	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,173,625	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		70,035	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		37,077,142	2.00
3.00	OPPS payments		34,635,115	3.00
4.00	Outlier payment (see instructions)		127,761	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		497,979	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		70,035	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		367,258	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)		367,258	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)		367,258	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		297,223	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)		70,035	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)		35,260,855	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		73,452	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,018,549	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)		29,238,889	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		274,420	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)		29,513,309	30.00
31.00	Primary payer payments		117	31.00
32.00	Subtotal (line 30 minus line 31)		29,513,192	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)		835,278	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		542,931	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		776,242	36.00
37.00	Subtotal (see instructions)		30,056,123	37.00
38.00	MSP-LCC reconciliation amount from PS&R		121	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		30,056,002	40.00
40.01	Sequestration adjustment (see instructions)		348,650	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		29,968,804	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-261,452	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems		BLESSING HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2019	Worksheet E	
		Component CCN: 14-S015	To 09/30/2020	Part B Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		136	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		33	2.00	
3.00	OPPS payments		207	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)		136	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		998	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)		998	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)		998	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		862	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)		136	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)		207	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)		10	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)		333	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)		333	30.00	
31.00	Primary payer payments		0	31.00	
32.00	Subtotal (line 30 minus line 31)		333	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)		0	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00	
37.00	Subtotal (see instructions)		333	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)		333	40.00	
40.01	Sequestration adjustment (see instructions)		4	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs			40.03	
41.00	Interim payments		349	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		-20	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00	
93.00	Time Value of Money (see instructions)		0	93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

Health Financial Systems		BLESSING HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2019	Worksheet E	
		Component CCN: 14-T015	To 09/30/2020	Part B Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		692	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00	
3.00	OPPS payments		0	3.00	
4.00	Outlier payment (see instructions)		0	4.00	
4.01	Outlier reconciliation amount (see instructions)		0	4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00	
6.00	Line 2 times line 5		0	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00	
8.00	Transitional corridor payment (see instructions)		0	8.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		692	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		5,082	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)		5,082	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)		5,082	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,390	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)		692	21.00	
22.00	Interns and residents (see instructions)		0	22.00	
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		692	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)		692	30.00	
31.00	Primary payer payments		0	31.00	
32.00	Subtotal (line 30 minus line 31)		692	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)		0	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00	
37.00	Subtotal (see instructions)		692	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)		692	40.00	
40.01	Sequestration adjustment (see instructions)		8	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs			40.03	
41.00	Interim payments		1,054	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		-370	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00	
93.00	Time Value of Money (see instructions)		0	93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		3,290	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		3,290	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		24,142	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)		24,142	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)		24,142	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		20,852	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)		3,290	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,290	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,290	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,290	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,290	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,290	40.00
40.01	Sequestration adjustment (see instructions)		38	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		23,868	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-20,616	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
12/30/2020 1:42 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		66,501,753		29,714,272	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	05/28/2020	254,532	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	01/30/2020	250,589		0	3.50
3.51		05/28/2020	125,146		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)		-375,735		254,532	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)		66,126,018		29,968,804	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		1,133,684		261,452	6.02
7.00	Total Medicare program liability (see instructions)		64,992,334		29,707,352	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: 14-0015
 Component CCN: 14-S015

 Period:
 From 10/01/2019
 To 09/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 12/30/2020 1:42 pm

		Title XVIII		Subprovider - IPF		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						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		242,286		349		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)		0		0		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)		242,286		349		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		62,849		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		20		6.02
7.00	Total Medicare program liability (see instructions)		305,135		329		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0015
 Component CCN: 14-T015

 Period:
 From 10/01/2019
 To 09/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 12/30/2020 1:42 pm

Title XVIII

 Subprovider -
 IRF

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					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		5,038,225		1,054	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/28/2020	19,017		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)		19,017		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)		5,057,242		1,054	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		103,120		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		370	6.02
7.00	Total Medicare program liability (see instructions)		5,160,362		684	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: 14-0015
 Component CCN: 14-5643

 Period:
 From 10/01/2019
 To 09/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 12/30/2020 1:42 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		1,958,217		23,868	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,958,217		23,868	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		37,104		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		20,616	6.02
7.00	Total Medicare program liability (see instructions)		1,995,321		3,252	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: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 12/30/2020 1:42 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		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part II Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	286,119		1.00
2.00	Net IPF PPS Outlier Payments	1,690		2.00
3.00	Net IPF PPS ECT Payments	0		3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00		4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		4.01
5.00	New Teaching program adjustment. (see instructions)	0.00		5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00		6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00		7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00		8.00
9.00	Average Daily Census (see instructions)	8.366120		9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.	0.000000		10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0		11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	287,809		12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0		13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0		15.00
16.00	Subtotal (see instructions)	287,809		16.00
17.00	Primary payer payments	0		17.00
18.00	Subtotal (line 16 less line 17).	287,809		18.00
19.00	Deductibles	35,464		19.00
20.00	Subtotal (line 18 minus line 19)	252,345		20.00
21.00	Coinsurance	5,115		21.00
22.00	Subtotal (line 20 minus line 21)	247,230		22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	74,003		23.00
24.00	Adjusted reimbursable bad debts (see instructions)	48,102		24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	64,623		25.00
26.00	Subtotal (sum of lines 22 and 24)	295,332		26.00
27.00	Direct graduate medical education payments (see instructions)	0		27.00
28.00	Other pass through costs (see instructions)	13,384		28.00
29.00	Outlier payments reconciliation	0		29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		30.50
30.99	Demonstration payment adjustment amount before sequestration	0		30.99
31.00	Total amount payable to the provider (see instructions)	308,716		31.00
31.01	Sequestration adjustment (see instructions)	3,581		31.01
31.02	Demonstration payment adjustment amount after sequestration	0		31.02
32.00	Interim payments	242,286		32.00
33.00	Tentative settlement (for contractor use only)	0		33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	62,849		34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	1,690		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part III Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)			4,836,745 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0289 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			210,398 3.00
4.00	Outlier Payments			183,894 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			12.628415 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			5,231,037 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			5,231,037 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			5,231,037 19.00
20.00	Deductibles			23,672 20.00
21.00	Subtotal (line 19 minus line 20)			5,207,365 21.00
22.00	Coinsurance			27,731 22.00
23.00	Subtotal (line 21 minus line 22)			5,179,634 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,179,634 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			41,291 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,220,925 32.00
32.01	Sequestration adjustment (see instructions)			60,563 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			5,057,242 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			103,120 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			183,894 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 12/30/2020 1:42 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)			2,062,845 1.00
2.00	Routine service other pass through costs			36,250 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,099,095 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			79,976 7.00
8.00	Allowable bad debts (see instructions)			1,316 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			1,316 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			855 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)			2,019,974 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)			2,019,974 15.00
15.01	Sequestration adjustment (see instructions)			24,653 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			10 15.75
16.00	Interim payments			1,958,217 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, 15.75, 16, and 17)			37,094 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015		Period: From 10/01/2019 To 09/30/2020		Worksheet E-4 Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					17.00	6.00
7.00	Enter the lesser of line 5 or line 6					17.00	7.00
		Primary Care	Other	Total			
		1.00	2.00	3.00			
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.00	0.00	17.00		8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	17.00	0.00	17.00		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01	
11.00	Total weighted FTE count	17.00	0.00	17.00		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.30	0.00	17.30		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	18.00	0.00	18.00		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.43	0.00	17.43		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	17.43	0.00	17.43		17.00	
18.00	Per resident amount	87,975.67	0.00	87,975.67		18.00	
19.00	Approved amount for resident costs	1,533,416	0	1,533,416		19.00	
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00	23.00
24.00	Multiply line 22 time line 23					0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)					1,533,416	25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions)	28,470	1,457	4,372			26.00
27.00	Total Inpatient Days (see instructions)	61,427	61,427	61,427			27.00
28.00	Ratio of inpatient days to total inpatient days	0.463477	0.023719	0.071174			28.00
29.00	Program direct GME amount	710,703	36,371	109,139	856,213		29.00
29.01	Percent reduction for MA DGME		7.00	7.00			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,546	7,640	10,186		30.00
31.00	Net Program direct GME amount				846,027		31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet E-4 Date/Time Prepared: 12/30/2020 1:42 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			3,309,080	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			78,708,241	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			24,121	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			78,684,120	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			37,776,597	42.00
43.00	Primary payer payments (see instructions)			1,616	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			37,774,981	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			116,459,101	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.675637	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.324363	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			846,027	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			571,607	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			274,420	50.00

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

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet G

Date/Time Prepared:
12/30/2020 1:42 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	145,223,318	0	0	0	1.00
2.00 Temporary investments	179,237,410	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	234,787,466	0	0	0	4.00
5.00 Other receivable	15,348,485	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-172,538,068	0	0	0	6.00
7.00 Inventory	10,373,371	0	0	0	7.00
8.00 Prepaid expenses	6,832,060	0	0	0	8.00
9.00 Other current assets	204,948	0	0	0	9.00
10.00 Due from other funds	5,046,283	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	424,515,273	0	0	0	11.00
FIXED ASSETS					
12.00 Land	16,129,930	0	0	0	12.00
13.00 Land improvements	9,837,381	0	0	0	13.00
14.00 Accumulated depreciation	-5,311,462	0	0	0	14.00
15.00 Buildings	305,295,455	0	0	0	15.00
16.00 Accumulated depreciation	-98,959,647	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	206,615,643	0	0	0	23.00
24.00 Accumulated depreciation	-127,928,224	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)	305,679,076	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	21,001,801	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	645,712	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	21,647,513	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	751,841,862	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	33,830,822	0	0	0	37.00
38.00 Salaries, wages, and fees payable	23,908,025	0	0	0	38.00
39.00 Payroll taxes payable	689,981	0	0	0	39.00
40.00 Notes and loans payable (short term)	2,344,900	0	0	0	40.00
41.00 Deferred income	1,678,783	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	79,043,637	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	141,496,148	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	118,155,811	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	69,547,065	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	187,702,876	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	329,199,024	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	422,642,838	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	422,642,838	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	751,841,862	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
12/30/2020 1:42 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		382,735,578		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43,055,925				2.00
3.00	Total (sum of line 1 and line 2)		425,791,503		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)		425,791,503		0		11.00
12.00	PENSION LIABILITY ADJUSTMENT	3,018,838		0		0	12.00
13.00	CHANGE IN RESTRICTED ASSETS	55,865		0		0	13.00
14.00	OTHER	73,962		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)		3,148,665		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		422,642,838		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	PENSION LIABILITY ADJUSTMENT		0				12.00
13.00	CHANGE IN RESTRICTED ASSETS		0				13.00
14.00	OTHER		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: 14-0015

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
12/30/2020 1:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	141,453,837		141,453,837	1.00
2.00	SUBPROVIDER - IPF	7,925,088		7,925,088	2.00
3.00	SUBPROVIDER - IRF	7,229,327		7,229,327	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	6,231,922		6,231,922	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)	162,840,174		162,840,174	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	53,078,723		53,078,723	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)	53,078,723		53,078,723	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	215,918,897		215,918,897	17.00
18.00	Ancillary services	551,379,674	841,179,900	1,392,559,574	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,578,954	1,578,954	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		7,244,203	7,244,203	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	56,915	5,387,837	5,444,752	26.00
27.00	NURSERY	3,634,828	0	3,634,828	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	770,990,314	855,390,894	1,626,381,208	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		440,848,155		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)		440,848,155		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
12/30/2020 1:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,626,381,208	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,193,626,448	2.00
3.00	Net patient revenues (line 1 minus line 2)	432,754,760	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	440,848,155	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,093,395	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	15,006,071	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	1,588,137	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	71,976	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	4,853,260	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	1,813,918	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	15,956,570	24.00
24.01	TRANSFERS	1,813,796	24.01
24.02	TRANSFERS	1,342,738	24.02
24.50	COVID-19 PHE Funding	8,702,854	24.50
25.00	Total other income (sum of lines 6-24)	51,149,320	25.00
26.00	Total (line 5 plus line 25)	43,055,925	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)	43,055,925	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015

Period:

Worksheet H

HHA CCN: 14-7031

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

12/30/2020 1:42 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	0	0	0	0	4.00
5.00 Administrative and General	629,144	0	0	0	0	629,144	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	1,040,045	0	127,400	0	334,123	1,501,568	6.00
7.00 Physical Therapy	984,235	0	74,193	0	194,583	1,253,011	7.00
8.00 Occupational Therapy	153,072	0	20,654	0	54,170	227,896	8.00
9.00 Speech Pathology	30,583	0	2,068	0	5,424	38,075	9.00
10.00 Medical Social Services	88,659	0	255	0	670	89,584	10.00
11.00 Home Health Aide	184,473	0	30,739	0	80,619	295,831	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	3,110,211	0	255,309	0	669,589	4,035,109	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	-2,719	626,425	-7,777	618,648			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	1,501,568	0	1,501,568			6.00
7.00 Physical Therapy	0	1,253,011	0	1,253,011			7.00
8.00 Occupational Therapy	0	227,896	0	227,896			8.00
9.00 Speech Pathology	0	38,075	0	38,075			9.00
10.00 Medical Social Services	0	89,584	0	89,584			10.00
11.00 Home Health Aide	0	295,831	0	295,831			11.00
12.00 Supplies (see instructions)	0	0	0	0			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	-2,719	4,032,390	-7,777	4,024,613			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: 14-0015

Period:

Worksheet H-1

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 pmHome 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				
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	618,648	0	0	0	0	618,648	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,501,568	0	0	0	0	1,501,568	6.00
7.00	Physical Therapy	1,253,011	0	0	0	0	1,253,011	7.00
8.00	Occupational Therapy	227,896	0	0	0	0	227,896	8.00
9.00	Speech Pathology	38,075	0	0	0	0	38,075	9.00
10.00	Medical Social Services	89,584	0	0	0	0	89,584	10.00
11.00	Home Health Aide	295,831	0	0	0	0	295,831	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,024,613	0	0	0	0	4,024,613	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	618,648						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	272,739	1,774,307					6.00
7.00	Physical Therapy	227,593	1,480,604					7.00
8.00	Occupational Therapy	41,394	269,290					8.00
9.00	Speech Pathology	6,916	44,991					9.00
10.00	Medical Social Services	16,272	105,856					10.00
11.00	Home Health Aide	53,734	349,565					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		4,024,613					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet H-1

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 pmHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Agency 1 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	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	0		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	0	0	-618,648	3,405,965	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	1,501,568	6.00	
7.00	Physical Therapy	0	0	0	0	0	1,253,011	7.00	
8.00	Occupational Therapy	0	0	0	0	0	227,896	8.00	
9.00	Speech Pathology	0	0	0	0	0	38,075	9.00	
10.00	Medical Social Services	0	0	0	0	0	89,584	10.00	
11.00	Home Health Aide	0	0	0	0	0	295,831	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0		0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	0	0	-618,648	3,405,965	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		618,648	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.181637	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

Home Health

PPS

Cost Center Description		HHA Trial Balance (1)		CAPITAL RELATED COSTS			Agency 1			
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	MOB PHASE I		
		0	1.00	1.01	1.02	1.03	1.04			
1.00	Administrative and General	0	0	0	0	0	0	0	1.00	
2.00	Skilled Nursing Care	1,774,307	0	0	0	0	0	0	2.00	
3.00	Physical Therapy	1,480,604	0	0	0	0	0	0	3.00	
4.00	Occupational Therapy	269,290	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	44,991	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	105,856	0	0	0	0	0	0	6.00	
7.00	Home Health Aide	349,565	0	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19) (2)	4,024,613	0	0	0	0	0	0	20.00	
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00	
Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL			
		OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP						
		1.05	1.06	2.00					4.00	4A
1.00	Administrative and General	28,306	0	641	401,460	430,407	134,046	1.00		
2.00	Skilled Nursing Care	0	0	0	0	1,774,307	552,589	2.00		
3.00	Physical Therapy	0	0	0	0	1,480,604	461,119	3.00		
4.00	Occupational Therapy	0	0	0	0	269,290	83,868	4.00		
5.00	Speech Pathology	0	0	0	0	44,991	14,012	5.00		
6.00	Medical Social Services	0	0	0	0	105,856	32,968	6.00		
7.00	Home Health Aide	0	0	0	0	349,565	108,869	7.00		
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00		
9.00	Drugs	0	0	0	0	0	0	9.00		
10.00	DME	0	0	0	0	0	0	10.00		
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00		
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00		
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00		
14.00	Clinic	0	0	0	0	0	0	14.00		
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00		
16.00	Day Care Program	0	0	0	0	0	0	16.00		
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00		
18.00	Homemaker Service	0	0	0	0	0	0	18.00		
19.00	All Others (specify)	0	0	0	0	0	0	19.00		
19.50	Telemedicine	0	0	0	0	0	0	19.50		
20.00	Total (sum of lines 1-19) (2)	28,306	0	641	401,460	4,455,020	1,387,471	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: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 pmHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	45,659	0	30,231	0	0	834,434	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	45,659	0	30,231	0	0	834,434	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	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
		16.00	20.00	21.00	22.00	23.00	23.01	
1.00	Administrative and General	0	39,948	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	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	39,948	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 pmHome Health
Agency I

PPS

Cost Center Description		PARAMED ED PRGM-LABORATOR Y	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATO RY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		23.02	23.03	23.04	23.05	24.00	25.00	
1.00	Administrative and General	0	0	0	0	1,514,725	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,326,896	0	2.00
3.00	Physical Therapy	0	0	0	0	1,941,723	0	3.00
4.00	Occupational Therapy	0	0	0	0	353,158	0	4.00
5.00	Speech Pathology	0	0	0	0	59,003	0	5.00
6.00	Medical Social Services	0	0	0	0	138,824	0	6.00
7.00	Home Health Aide	0	0	0	0	458,434	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	6,792,763	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	1,514,725						1.00
2.00	Skilled Nursing Care	2,326,896	667,789	2,994,685				2.00
3.00	Physical Therapy	1,941,723	557,247	2,498,970				3.00
4.00	Occupational Therapy	353,158	101,351	454,509				4.00
5.00	Speech Pathology	59,003	16,933	75,936				5.00
6.00	Medical Social Services	138,824	39,841	178,665				6.00
7.00	Home Health Aide	458,434	131,564	589,998				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	6,792,763	1,514,725	6,792,763				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.		0.286986					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: 14-0015
HHA CCN: 14-7031Period:
From 10/01/2019
To 09/30/2020Worksheet H-2
Part II
Date/Time Prepared:
12/30/2020 1:42 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					OAK STREET MALL (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)		
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	0	2,050	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	2,050	20.00
21.00	Total cost to be allocated	0	0	0	0	0	28,306	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	13.807805	22.00
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BRCN AT 36TH ST (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.06	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	641	3,110,211	0	430,407	2,050	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,774,307	0	2.00
3.00	Physical Therapy	0	0	0	0	1,480,604	0	3.00
4.00	Occupational Therapy	0	0	0	0	269,290	0	4.00
5.00	Speech Pathology	0	0	0	0	44,991	0	5.00
6.00	Medical Social Services	0	0	0	0	105,856	0	6.00
7.00	Home Health Aide	0	0	0	0	349,565	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	641	3,110,211		4,455,020	2,050	20.00
21.00	Total cost to be allocated	0	641	401,460		1,387,471	45,659	21.00
22.00	Unit cost multiplier	0.000000	1.000000	0.129078		0.311440	22.272683	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2019

Part II

To 09/30/2020

Date/Time Prepared:

12/30/2020 1:42 pm

Home Health
Agency I

PPS

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	509	0	0	87,932	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	509	0	0	87,932	0	20.00
21.00	Total cost to be allocated	0	30,231	0	0	834,434	0	21.00
22.00	Unit cost multiplier	0.000000	59.392927	0.000000	0.000000	9.489537	0.000000	22.00
Cost Center Description		INTERNS & RESIDENTS						
		NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATOR Y	
		(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	
		20.00	21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	116	0	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	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)	116	0	0	0	0	0	20.00
21.00	Total cost to be allocated	39,948	0	0	0	0	0	21.00
22.00	Unit cost multiplier	344.379310	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015
HHA CCN: 14-7031Period:
From 10/01/2019
To 09/30/2020Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description		PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)		
		23.03	23.04	23.05		
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet H-3

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 pm

				Title XVIII		Home Health Agency I	12/30/2020 1:42 pm 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	2,994,685		2,994,685	20,867	143.51	1.00
2.00	Physical Therapy	3.00	2,498,970	0	2,498,970	12,156	205.58	2.00
3.00	Occupational Therapy	4.00	454,509	0	454,509	3,384	134.31	3.00
4.00	Speech Pathology	5.00	75,936	0	75,936	340	223.34	4.00
5.00	Medical Social Services	6.00	178,665		178,665	42	4,253.93	5.00
6.00	Home Health Aide	7.00	589,998		589,998	5,035	117.18	6.00
7.00	Total (sum of lines 1-6)		6,792,763	0	6,792,763	41,824		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	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		99914	0	8,516			8.00
8.01	Skilled Nursing Care		99916	0	0			8.01
8.02	Skilled Nursing Care		99926	0	2,080			8.02
9.00	Physical Therapy		99914	0	5,780			9.00
9.01	Physical Therapy		99916	0	3			9.01
9.02	Physical Therapy		99926	0	1,550			9.02
10.00	Occupational Therapy		99914	0	1,720			10.00
10.01	Occupational Therapy		99916	0	4			10.01
10.02	Occupational Therapy		99926	0	343			10.02
11.00	Speech Pathology		99914	0	97			11.00
11.01	Speech Pathology		99916	0	0			11.01
11.02	Speech Pathology		99926	0	23			11.02
12.00	Medical Social Services		99914	0	22			12.00
12.01	Medical Social Services		99916	0	1			12.01
12.02	Medical Social Services		99926	0	3			12.02
13.00	Home Health Aide		99914	0	2,488			13.00
13.01	Home Health Aide		99916	0	2			13.01
13.02	Home Health Aide		99926	0	470			13.02
14.00	Total (sum of lines 8-13)			0	23,102			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	111,753	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			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
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	10,596		0	1,520,632		1.00
2.00	Physical Therapy	0	7,333		0	1,507,518		2.00
3.00	Occupational Therapy	0	2,067		0	277,619		3.00
4.00	Speech Pathology	0	120		0	26,801		4.00
5.00	Medical Social Services	0	26		0	110,602		5.00
6.00	Home Health Aide	0	2,960		0	346,853		6.00
7.00	Total (sum of lines 1-6)	0	23,102		0	3,790,025		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet H-3

HHA CCN: 14-7031

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

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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	111,753	0	0	0		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	1,520,632							1.00
2.00	Physical Therapy	1,507,518							2.00
3.00	Occupational Therapy	277,619							3.00
4.00	Speech Pathology	26,801							4.00
5.00	Medical Social Services	110,602							5.00
6.00	Home Health Aide	346,853							6.00
7.00	Total (sum of lines 1-6)	3,790,025							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: 14-0015

Period:

Worksheet H-3

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 pm

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Home Health
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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	0.439128	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.321994	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.264184	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.173694	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.136262	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0015

Period:

Worksheet H-4

HHA CCN: 14-7031

From 10/01/2019
To 09/30/2020Part I-II
Date/Time Prepared:
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Title XVIII

Home Health
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		Agency 1		Agency 2	
		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	1.00
2.00	Total charges	0	3,811,293	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	3,811,293	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	3,811,293	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	1,499	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	-1,499	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	3,524,317	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	70,846	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	44,531	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	24,308	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	22,029	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	3,684,532	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	3,684,532	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		0	3,684,532	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,684,532	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	3,684,532	31.00
31.01	Sequestration adjustment (see instructions)		0	50,758	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	3,633,774	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

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

Provider CCN: 14-0015

Period:

Worksheet H-5

HHA CCN: 14-7031

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

12/30/2020 1:42 pm

Home Health
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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		3,633,774	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		3,633,774	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		3,633,774	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: 14-0015

Period:

Worksheet 0

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	371,744	58,195	429,939	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	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*	0	0	0	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	90,733	90,733	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	16,510	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	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	60,755	74,819	135,574	0	26.00
27.00	NURSE PRACTITIONER**	30,518	1,143	31,661	0	27.00
28.00	REGISTERED NURSE**	602,339	0	602,339	-1,932	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**	158,321	0	158,321	0	33.00
34.00	SPIRITUAL COUNSELING**	71,626	0	71,626	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**	79,188	6,028	85,216	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	123,602	123,602	0	38.00
39.00	PATIENT TRANSPORTATION**	0	6,808	6,808	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	1,865	1,865	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	55,209	55,209	-4,863	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	197,727	197,727	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)**	926	0	926	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*	73,241	0	73,241	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	1,448,658	616,129	2,064,787	9,715	2,074,502

* 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: 14-0015

Period:

Worksheet 0

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	429,939	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	90,733	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	16,510	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	194,162	194,162	25.00
26.00	PHYSICIAN SERVICES**	-23,977	111,597	26.00
27.00	NURSE PRACTITIONER**	0	31,661	27.00
28.00	REGISTERED NURSE**	0	600,407	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	158,321	33.00
34.00	SPIRITUAL COUNSELING**	0	71,626	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	85,216	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	123,602	38.00
39.00	PATIENT TRANSPORTATION**	0	6,808	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	1,865	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	50,346	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	197,727	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	926	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	73,241	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	170,185	2,244,687	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 ROUTINE HOME CARE			Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet 0-2
			Hospice CCN: 14-1501		Date/Time Prepared: 12/30/2020 1:42 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	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	60,755	74,819	135,574	0	135,574	26.00
27.00	NURSE PRACTITIONER	30,518	1,143	31,661	0	31,661	27.00
28.00	REGISTERED NURSE	572,450	0	572,450	-1,932	570,518	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	154,022	0	154,022	0	154,022	33.00
34.00	SPIRITUAL COUNSELING	69,804	0	69,804	0	69,804	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	79,188	6,028	85,216	0	85,216	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	123,602	123,602	0	123,602	38.00
39.00	PATIENT TRANSPORTATION	0	6,808	6,808	0	6,808	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	1,865	1,865	0	1,865	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	55,209	55,209	-4,863	50,346	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	197,727	197,727	0	197,727	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)	926	0	926	0	926	46.00
100.00	TOTAL *	967,663	467,201	1,434,864	-6,795	1,428,069	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	-23,977	111,597	26.00
27.00	NURSE PRACTITIONER	0	31,661	27.00
28.00	REGISTERED NURSE	0	570,518	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	154,022	33.00
34.00	SPIRITUAL COUNSELING	0	69,804	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	85,216	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	123,602	38.00
39.00	PATIENT TRANSPORTATION	0	6,808	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	1,865	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	50,346	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	197,727	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	926	46.00
100.00	TOTAL *	-23,977	1,404,092	100.00

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

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

Provider CCN: 14-0015

Period:

Worksheet 0-4

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	29,889	0	29,889	0	29,889	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	4,299	0	4,299	0	4,299	33.00
34.00	SPIRITUAL COUNSELING	1,822	0	1,822	0	1,822	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	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	36,010	0	36,010	0	36,010	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	194,162	194,162	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	29,889	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	4,299	33.00
34.00	SPIRITUAL COUNSELING	0	1,822	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	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	194,162	230,172	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: 14-0015

Period:

Worksheet 0-5

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,099	7,099	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	188,577	188,577	3.00
4.00	ADMINISTRATIVE & GENERAL	429,939	760,027	1,189,966	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	431,594	431,594	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	90,733	0	90,733	12.00
13.00	VOLUNTEER SERVICE COORDINATION	16,510	0	16,510	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	22,729	22,729	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,404,092	0	1,404,092	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	230,172	0	230,172	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	73,241	0	73,241	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	2,244,687	1,410,026	3,654,713	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

12/30/2020 1:42 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	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,099			7,099			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	188,577		0	0	188,577		3.00
4.00	ADMINISTRATIVE & GENERAL	1,189,966		0	7,099	47,984	1,245,049	4.00
5.00	PLANT OPERATION & MAINTENANCE	0		0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0		0	0	0	0	6.00
7.00	HOUSEKEEPING	0		0	0	0	0	7.00
8.00	DIETARY	0		0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	431,594		0	0	0	431,594	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0	0	0	0	10.00
11.00	MEDICAL RECORDS	0		0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	90,733		0	0	0	90,733	12.00
13.00	VOLUNTEER SERVICE COORDINATION	16,510		0	0	1,836	18,346	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	22,729		0	0	0	22,729	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	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,404,092				124,655	1,528,747	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	230,172		0	0	4,648	234,820	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	73,241		0	0	9,454	82,695	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0		0	0	0	0	66.00
67.00	ADVERTISING	0		0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	0	0	0	68.00
69.00	THRIFT STORE	0		0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0	0	0	0	99.00
100.00	TOTAL	3,654,713		0	7,099	188,577	3,654,713	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 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	1,245,049						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	223,000	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			0		10.00
11.00	MEDICAL RECORDS	0	0			0		11.00
12.00	STAFF TRANSPORTATION	46,881	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	9,479	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	11,744	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	789,888						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	121,329	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	42,728	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	1,245,049	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 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					
2.00	CAP REL COSTS-MVBLE EQUIP					
3.00	EMPLOYEE BENEFITS DEPARTMENT					
4.00	ADMINISTRATIVE & GENERAL					
5.00	PLANT OPERATION & MAINTENANCE					
6.00	LAUNDRY & LINEN SERVICE					
7.00	HOUSEKEEPING					
8.00	DIETARY					
9.00	NURSING ADMINISTRATION	654,594				
10.00	ROUTINE MEDICAL SUPPLIES	0	0			
11.00	MEDICAL RECORDS	0		0		
12.00	STAFF TRANSPORTATION	0			137,614	
13.00	VOLUNTEER SERVICE COORDINATION	0			0	27,825
14.00	PHARMACY	0			0	0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0
16.00	OTHER GENERAL SERVICE	0			0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0
51.00	HOSPICE ROUTINE HOME CARE	646,721	0	0	135,959	27,490
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0
53.00	HOSPICE GENERAL INPATIENT CARE	7,873	0	0	1,655	335
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0
61.00	VOLUNTEER PROGRAM	0			0	0
62.00	FUNDRAISING	0			0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0
64.00	PALLIATIVE CARE PROGRAM	0			0	0
65.00	OTHER PHYSICIAN SERVICES	0			0	0
66.00	RESIDENTIAL CARE	0			0	0
67.00	ADVERTISING	0			0	0
68.00	TELEHEALTH/TELEMONITORING	0			0	0
69.00	THRIFT STORE	0			0	0
70.00	NURSING FACILITY ROOM & BOARD					
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	654,594	0	0	137,614	27,825

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
12/30/2020 1:42 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		34,473			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	34,473		3,163,278	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	366,012	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		125,423	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	34,473	0	3,654,713	100.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 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	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		7,095				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,460,952			3.00
4.00	ADMINISTRATIVE & GENERAL	0	7,095	371,744	-1,245,049	2,409,664	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	431,594	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	90,733	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	14,226	0	18,346	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	22,729	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	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			965,731	0	1,528,747	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	36,010	0	234,820	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	73,241	0	82,695	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)	0	7,099	188,577		1,245,049	100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.000564	0.129078		0.516690	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 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	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0				45,481	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0		10.00
11.00	MEDICAL RECORDS	0			0		11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0		13.00
14.00	PHARMACY	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0		15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					44,934	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	547	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)	0	0	0	0	654,594	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	14.392691	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 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	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			45,481			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	45,481		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	44,934	44,934	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	547	547	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	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	0	137,614	27,825	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	3.025747	0.611794	0.000000	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
12/30/2020 1:42 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		100			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	100			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	34,473	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	344.730000	0.000000		101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-7

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020

Date/Time Prepared:
12/30/2020 1:42 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	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.439128	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.321994	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.264184	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.136262	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.087186	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.173694	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.165978	0	0	0	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	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
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	0	0	0	0	0	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: 14-0015

Period:

Worksheet 0-8

Hospice CCN: 14-1501

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			3,163,278	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			20,953	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			150.97	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	19,531	553		9.00
10.00	Program cost (line 8 times line 9)	2,948,595	83,486		10.00
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)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
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)			366,012	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			547	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			669.13	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	436	45		19.00
20.00	Program cost (line 18 times line 19)	291,741	30,111		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,529,290	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			21,500	22.00
23.00	Average cost per diem (line 21 divided by line 22)			164.15	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 12/30/2020 1:42 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,018,297	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		272,672	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)		149.00	3.00
4.00	Number of interns & residents (see instructions)		13.16	4.00
5.00	Indirect medical education percentage (see instructions)		2.52	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)		101,261	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)		4,392,230	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: 14-0015

Period:

Worksheet M-1

Component CCN: 14-3422

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 pm

		RHC I		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	222,044	0	222,044	0	222,044
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	153,511	0	153,511	0	153,511
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
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	207,446	0	207,446	0	207,446
10.00	Subtotal (sum of lines 1 through 9)	583,001	0	583,001	0	583,001
11.00	Physician Services Under Agreement	0	125,364	125,364	0	125,364
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	90	90	0	90
14.00	Subtotal (sum of lines 11 through 13)	0	125,454	125,454	0	125,454
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	52,963	52,963	-1,189	51,774
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	52,963	52,963	-1,189	51,774
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	583,001	178,417	761,418	-1,189	760,229
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	12,003	4,353	16,356	0	16,356
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)	12,003	4,353	16,356	0	16,356
FACILITY OVERHEAD						
29.00	Facility Costs	0	93,516	93,516	11,245	104,761
30.00	Administrative Costs	94,131	30,220	124,351	0	124,351
31.00	Total Facility Overhead (sum of lines 29 and 30)	94,131	123,736	217,867	11,245	229,112
32.00	Total facility costs (sum of lines 22, 28 and 31)	689,135	306,506	995,641	10,056	1,005,697

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015

Period:

Worksheet M-1

Component CCN: 14-3422

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 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	-35,062	186,982	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	153,511	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	-140	207,306	9.00
10.00	Subtotal (sum of lines 1 through 9)	-35,202	547,799	10.00
11.00	Physician Services Under Agreement	0	125,364	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	90	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	125,454	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	-40	51,734	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-40	51,734	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-35,242	724,987	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	16,356	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	16,356	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-51,597	53,164	29.00
30.00	Administrative Costs	30,049	154,400	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-21,548	207,564	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-56,790	948,907	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015

Period:

Worksheet M-2

Component CCN: 14-3422

From 10/01/2019
To 09/30/2020Date/Time Prepared:
12/30/2020 1:42 pm

				RHC I		12/30/2020 1:42 pm	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	Cost
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.95	2,190	4,200	3,990		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.18	2,820	2,100	2,478		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.13	5,010		6,468	6,468	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	0.32	348			348	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)	2.45	5,358			6,816	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)					724,987	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					16,356	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					741,343	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.977937	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					207,564	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					412,183	15.00
16.00	Total overhead (sum of lines 14 and 15)					619,747	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					619,747	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					606,074	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,331,061	20.00

Health Financial Systems		BLESSING HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 14-3422		Date/Time Prepared: 12/30/2020 1:42 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)			1,331,061	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,420	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,300,641	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,816	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)			6,816	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			190.82	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)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		84.70	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		426	1,011	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		36,082	87,259	11.00
12.00	Program covered visits for mental health services (from contractor records)		13	33	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		1,101	2,848	13.00
14.00	Limit adjustment for mental health services (see instructions)		1,101	2,848	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	127,290	16.00
16.01	Total program charges (see instructions)(from contractor's records)			347,119	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			31,715	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			11,630	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.)			65,889	16.04
16.05	Total program cost (see instructions)		0	77,519	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			33,299	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			56,421	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			77,519	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			13,052	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			90,571	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			90,571	26.00
26.01	Sequestration adjustment (see instructions)			1,051	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			72,289	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)			17,231	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: 14-0015 Component CCN: 14-3422	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 12/30/2020 1:42 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)		547,799	547,799	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001003	0.005604	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		549	3,070	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,187	7,763	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,736	10,833	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		724,987	724,987	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		606,074	606,074	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.007912	0.014942	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,795	9,056	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		10,531	19,889	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		109	609	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		96.61	32.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		56	234	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		5,410	7,642	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)			30,420	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)			13,052	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 12/30/2020 1:42 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		72,289	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)		72,289	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		17,231	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		89,520	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00