

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 Provider CCN: 14-0143
SETTLEMENT SUMMARY

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

Worksheet S
Parts I-III
Date/Time Prepared:
4/28/2021 3:00 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/28/2021	Time: 3:00 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 ST. MARGARET'S HOSPITAL (14-0143) 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 A. Muntz
Officer or Administrator of Provider(s)

President & CEO

Title

April 28, 2021

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	-2,020,017	-47	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	-2,020,017	-47	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: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 3:00 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 600 EAST FIRST ST			PO Box:				1.00	
2.00	City: SPRING VALLEY			State: IL		Zip Code: 61362		County: BUREAU	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N
4.00	Subprovider - IPF							P	P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	N
8.00	Swing Beds - NF							P	N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice			ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998	
15.00	Hospital-Based Health Clinic - RHC								
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	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			575	0	0	0	115	2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 3:00 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural St	Date of Geogra		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		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.					10/01/2019	09/30/2020	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	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

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	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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0143

Period:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00	

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N 80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N 81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N 85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N 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 1.00	XIX 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.			Y Y 98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?			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)			N 106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N 107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N 108.00
			Physical 1.00	Occupational 2.00
			Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N N N N 109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N 110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 3:00 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
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.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	477,273	0	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.	N	Y	120.00
121.00	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.			121.00
122.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		122.00
123.00	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		123.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
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	35H002	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 3:00 pm			
1.00		2.00		3.00							
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.											
141.00	Name: SISTERS MARY OF THE PRESENTATION HC			Contractor's Name: NORIDIAN ADMIN SVC		Contractor's Number: 03001		141.00			
142.00	Street: 1202 PAGE DR SW PO BOX 10007			PO Box:				142.00			
143.00	City: FARGO			State: ND		Zip Code: 58106-0007		143.00			
								1.00			
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00	
								1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.									145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								N	146.00	
								1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00	
				Part A	Part B	Title V	Title XIX				
				1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)											
155.00	Hospital			N	N	N	N			155.00	
156.00	Subprovider - IPF			N	N	N	N			156.00	
157.00	Subprovider - IRF			N	N	N	N			157.00	
158.00	SUBPROVIDER									158.00	
159.00	SNF			N	N	N	N			159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00	
161.00	CMHC				N	N	N			161.00	
								1.00			
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00	
				Name	County	State	Zip Code	CBSA	FTE/Campus		
				0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00	
								1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act											
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00	
								Beginning	Ending		
								1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00	
								1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 3:00 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y		15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
					4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/04/2021	Y	02/04/2021
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.	Y		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 3:00 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:	PIIP PYMTS WERE ENTERED AS PAYMENT.	Y	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Don	TROGLIO		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328	DTROGLIO@ABOUTSMG.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 3:00 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF ACCOUNTING		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: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 3:00 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	38	13,908	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)		38	13,908	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	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)		44	16,104	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	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)		44				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: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 3:00 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)	2,726	402	4,585			1.00
2.00 HMO and other (see instructions)	765	115				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,726	402	4,585			7.00
8.00 INTENSIVE CARE UNIT	360	55	697			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		118	467			13.00
14.00 Total (see instructions)	3,086	575	5,749	0.00	577.96	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	6.84	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	584.80	27.00
28.00 Observation Bed Days		465	2,557			28.00
29.00 Ambulance Trips	352					29.00
30.00 Employee discount days (see instruction)			22			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	2	117			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: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 3:00 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	785	241	1,592	1.00
2.00 HMO and other (see instructions)			161	54		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	785	241	1,592	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	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: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

	Wkst. A Line Number	Amount Reported	Reclassification 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	38,359,349	847,604	39,206,953	1,218,968.59	32.16
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		0	9,847	9,847	54.00	182.35
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		7,568,993	860,477	8,429,470	48,557.00	173.60
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,388,768	131,281	1,520,049	56,890.27	26.72
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		392,773	0	392,773	5,838.80	67.27
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		866,695	0	866,695	5,558.31	155.93
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		1,243,745	0	1,243,745	8,027.00	154.95
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
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)		6,103,269	0	6,103,269		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		286,915	0	286,915		
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		732	0	732		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		625,872	0	625,872		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		266,032	0	266,032		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	216,225	0	216,225	8,322.50	25.98
27.00	Administrative & General	5.00	3,483,156	-131,281	3,351,875	145,539.30	23.03
28.00	Administrative & General under contract (see inst.)		1,060,875	0	1,060,875	2,387.12	444.42
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	580,581	0	580,581	24,210.05	23.98

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/28/2021 3:00 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	
31.00	Laundry & Linen Service	8.00	0	46,724	46,724	3,641.25	12.83	31.00
32.00	Housekeeping	9.00	618,761	-46,724	572,037	39,009.70	14.66	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	841,573	-640,690	200,883	12,333.61	16.29	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	640,690	640,690	39,336.29	16.29	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,159,277	0	1,159,277	28,286.59	40.98	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	1,542,581	0	1,542,581	54,562.75	28.27	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: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/28/2021 3:00 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)	31,851,231	-12,873	31,838,358	1,172,798.71	27.15	1.00
2.00	Excluded area salaries (see instructions)	1,388,768	131,281	1,520,049	56,890.27	26.72	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,462,463	-144,154	30,318,309	1,115,908.44	27.17	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,503,213	0	2,503,213	19,424.11	128.87	4.00
5.00	Subtotal wage-related costs (see inst.)	6,370,033	0	6,370,033	0.00	21.01	5.00
6.00	Total (sum of lines 3 thru 5)	39,335,709	-144,154	39,191,555	1,135,332.55	34.52	6.00
7.00	Total overhead cost (see instructions)	9,503,029	-131,281	9,371,748	357,629.16	26.21	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
4/28/2021 3:00 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	903,042	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,884,751	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	198,848	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	39,311	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	3,472	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	196,074	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	225,669	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	1,984,750	17.00
18.00	Medicare Taxes - Employers Portion Only	543,676	18.00
19.00	Unemployment Insurance	24,829	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	12,365	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,016,787	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: 14-0143

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 4/28/2021 3:00 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	392,773	7,016,787	1.00
2.00	Hospital	392,773	7,016,787	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA				Provider CCN: 14-0143 Hospice CCN: 14-1595		Period: From 10/01/2019 To 09/30/2020		Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 4/28/2021 3:00 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		3,003	0	0	3,003	11.00
12.00	Hospice Inpatient Respite Care		0	0	0	0	12.00
13.00	Hospice General Inpatient Care		98	0	0	98	13.00
14.00	Total Hospice Days		3,101	0	0	3,101	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015							
15.00	Hospice Inpatient Respite Care		0	0	0	0	15.00
16.00	Hospice General Inpatient Care		0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0143

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

Worksheet S-10

Date/Time Prepared:
4/28/2021 3:00 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)	0.329041	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	2,794,387	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	28,889,163	6.00
7.00	Medicaid cost (line 1 times line 6)	9,505,719	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)	6,711,332	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	3,250	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,711,332	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)			
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,311,245	1,032,500
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	760,494	1,032,500
22.00	Payments received from patients for amounts previously written off as charity care	48,330	96,358
23.00	Cost of charity care (line 21 minus line 22)	712,164	936,142
		1.00	2.00
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)	1,847,411	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	236,080	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	363,200	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,484,211	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	615,486	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,263,792	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,975,124	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet A Date/Time Prepared: 4/28/2021 3:00 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	NEW CAP REL COSTS-BLDG & FIXT				3,654,337		3,654,337		-363,245		3,291,092		1.00	
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT				450		450		0		450		1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2,681,698		2,681,698		141,293		2,822,991		2.00	
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP				0		0		0		0		2.01	
3.00	00300	OTHER CAPITAL RELATED COSTS				0		0		0		0		3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		216,225		7,168,894		7,385,119		0		7,385,119		4.00	
5.00	00500	ADMINISTRATIVE & GENERAL		3,483,156		7,564,430		11,047,586		-158,511		10,889,075		5.00	
7.00	00700	OPERATION OF PLANT		580,581		1,501,795		2,082,376		0		2,082,376		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE		0		165,286		165,286		46,724		212,010		8.00	
9.00	00900	HOUSEKEEPING		618,761		261,719		880,480		-46,724		833,756		9.00	
10.00	01000	DIETARY		841,573		420,362		1,261,935		-960,725		301,210		10.00	
11.00	01100	CAFETERIA		0		0		0		960,725		960,725		11.00	
13.00	01300	NURSING ADMINISTRATION		1,159,277		93,756		1,253,033		0		1,253,033		13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY		1,542,581		342,974		1,885,555		0		1,885,555		16.00	
17.00	01700	SOCIAL SERVICE		0		0		0		0		0		17.00	
INPATIENT ROUTINE SERVICE COST CENTERS															
30.00	03000	ADULTS & PEDIATRICS		3,042,759		1,279,254		4,322,013		-80,975		4,241,038		30.00	
31.00	03100	INTENSIVE CARE UNIT		738,645		44,358		783,003		0		783,003		31.00	
43.00	04300	NURSERY		59,560		140,488		200,048		0		200,048		43.00	
ANCILLARY SERVICE COST CENTERS															
50.00	05000	OPERATING ROOM		2,067,819		3,985,903		6,053,722		0		6,053,722		50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM		290,952		72,709		363,661		80,975		444,636		52.00	
53.00	05300	ANESTHESIOLOGY		0		1,957,261		1,957,261		0		1,957,261		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		830,434		1,443,458		2,273,892		0		2,273,892		54.00	
54.01	05402	NUCLEAR MEDICINE		186,590		0		186,590		0		186,590		54.01	
57.00	05700	CT SCAN		155,687		384,188		539,875		0		539,875		57.00	
60.00	06000	LABORATORY		1,042,922		2,625,055		3,667,977		0		3,667,977		60.00	
60.01	06001	BLOOD LABORATORY		0		0		0		0		0		60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0		216,130		216,130		0		216,130		63.00	
65.00	06500	RESPIRATORY THERAPY		418,137		108,197		526,334		0		526,334		65.00	
66.00	06600	PHYSICAL THERAPY		1,349,271		102,965		1,452,236		0		1,452,236		66.00	
67.00	06700	OCCUPATIONAL THERAPY		137,087		1,983		139,070		0		139,070		67.00	
68.00	06800	SPEECH PATHOLOGY		70,416		3,160		73,576		0		73,576		68.00	
69.00	06900	ELECTROCARDIOLOGY		109,072		158,085		267,157		0		267,157		69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY		60,958		74,726		135,684		0		135,684		70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		45,508		238,115		283,623		0		283,623		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0		2,164,898		2,164,898		0		2,164,898		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		789,561		1,984,157		2,773,718		0		2,773,718		73.00	
76.00	03020	SONOGRAPHY		189,706		370,689		560,395		0		560,395		76.00	
76.01	03040	AUDIOLOGY		0		0		0		183,095		183,095		76.01	
76.02	03160	CARDIAC REHAB		179,615		22,334		201,949		0		201,949		76.02	
OUTPATIENT SERVICE COST CENTERS															
88.00	08800	RURAL HEALTH CLINIC		0		0		0		0		0		88.00	
90.00	09000	CLINIC		15,756,864		4,027,713		19,784,577		1,128,375		20,912,952		90.00	
91.00	09100	EMERGENCY		1,006,864		1,175,014		2,181,878		0		2,181,878		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		0		0		0		92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0		0		0		0		0		93.00	
OTHER REIMBURSABLE COST CENTERS															
95.00	09500	AMBULANCE SERVICES		0		690,851		690,851		0		690,851		95.00	
SPECIAL PURPOSE COST CENTERS															
113.00	11300	INTEREST EXPENSE		0		1,099,797		1,099,797		-1,099,797		0		113.00	
114.00	11400	UTILIZATION REVIEW-SNF		0		0		0		0		0		114.00	
116.00	11600	HOSPICE		483,225		609,656		1,092,881		0		1,092,881		116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)		37,453,806		48,836,845		86,290,651		-168,790		86,121,861		118.00	
NONREIMBURSABLE COST CENTERS															
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0		0		0		0		190.00	
194.00	07950	CONGREGATE LIVING		37,982		1,650		39,632		0		39,632		194.00	
194.01	07951	OTHER		0		0		0		0		0		194.01	
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN		0		0		0		0		0		194.02	
194.03	07953	MANAGED CARE		53,138		17,012		70,150		0		70,150		194.03	
194.04	07954	RENTAL AREA/PPOS		0		0		0		0		0		194.04	
194.05	07955	SPECIALTY CLINICS		0		1,822		1,822		0		1,822		194.05	
194.08	07958	ENT		0		0		0		0		0		194.08	
194.09	07959	DURABLE MEDICAL EQUIPMENT		242,047		397,259		639,306		0		639,306		194.09	
194.10	07960	PERU MALL		0		0		0		0		0		194.10	
194.12	07962	FAMILY ORTHOPEDIC CENTER		0		0		0		0		0		194.12	
194.13	07963	WOMEN'S HEALTH CENTER		0		0		0		0		0		194.13	
194.14	07964	HENRY		0		0		0		0		0		194.14	
194.16	07966	SPRING VALLEY CLINIC		0		0		0		0		0		194.16	
194.17	07967	OGLESBY MP OB		0		0		0		0		0		194.17	
194.18	07968	FAMILY HEALTH CENTER		0		0		0		0		0		194.18	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020	Worksheet A Date/Time Prepared: 4/28/2021 3:00 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
194.19	07969	GRANVILLE CLINIC		0	0	0	0	0
194.20	07970	PARATRANSIT		0	0	0	168,790	168,790
194.21	07971	OCCUPATIONAL HEALTH		445,127	141,779	586,906	0	586,906
194.24	07974	SURGICAL ASSOCIATES		0	193	193	0	193
194.27	07977	MIDTOWN		0	0	0	0	0
194.28	07978	PAIN CLINIC		127,249	85,514	212,763	0	212,763
194.30	07980	WHC-PTON		0	0	0	0	0
194.31	07981	CFH		0	0	0	0	0
194.32	07982	PFS		0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)		38,359,349	49,482,074	87,841,423	0	87,841,423

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet A Date/Time Prepared: 4/28/2021 3:00 pm
Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-31,242	3,259,850	1.00	
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	450	1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,709	2,826,700	2.00	
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	57	57	2.01	
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,251,634	6,133,485	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	-280,959	10,608,116	5.00	
7.00	00700	OPERATION OF PLANT	-1,800	2,080,576	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	212,010	8.00	
9.00	00900	HOUSEKEEPING	0	833,756	9.00	
10.00	01000	DIETARY	0	301,210	10.00	
11.00	01100	CAFETERIA	-219,159	741,566	11.00	
13.00	01300	NURSING ADMINISTRATION	-88,356	1,164,677	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,021	1,884,534	16.00	
17.00	01700	SOCIAL SERVICE	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	-966,156	3,274,882	30.00	
31.00	03100	INTENSIVE CARE UNIT	-9,600	773,403	31.00	
43.00	04300	NURSERY	-112,543	87,505	43.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,053,722	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	444,636	52.00	
53.00	05300	ANESTHESIOLOGY	-1,718,518	238,743	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,273,892	54.00	
54.01	05402	NUCLEAR MEDICINE	0	186,590	54.01	
57.00	05700	CT SCAN	0	539,875	57.00	
60.00	06000	LABORATORY	0	3,667,977	60.00	
60.01	06001	BLOOD LABORATORY	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	216,130	63.00	
65.00	06500	RESPIRATORY THERAPY	0	526,334	65.00	
66.00	06600	PHYSICAL THERAPY	-2,030	1,450,206	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	139,070	67.00	
68.00	06800	SPEECH PATHOLOGY	0	73,576	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	267,157	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	135,684	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	283,623	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,164,898	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	-193,662	2,580,056	73.00	
76.00	03020	SONOGRAPHY	0	560,395	76.00	
76.01	03040	AUDIOLOGY	0	183,095	76.01	
76.02	03160	CARDIAC REHAB	0	201,949	76.02	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
90.00	09000	CLINIC	-7,815,713	13,097,239	90.00	
91.00	09100	EMERGENCY	-321,839	1,860,039	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	690,851	95.00	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	113.00	
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00	
116.00	11600	HOSPICE	0	1,092,881	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,010,466	73,111,395	118.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00	
194.00	07950	CONGREGATE LIVING	0	39,632	194.00	
194.01	07951	OTHER	0	0	194.01	
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	194.02	
194.03	07953	MANAGED CARE	0	70,150	194.03	
194.04	07954	RENTAL AREA/PPOS	0	0	194.04	
194.05	07955	SPECIALTY CLINICS	0	1,822	194.05	
194.08	07958	ENT	0	0	194.08	
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	639,306	194.09	
194.10	07960	PERU MALL	0	0	194.10	
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	194.12	
194.13	07963	WOMEN'S HEALTH CENTER	0	0	194.13	
194.14	07964	HENRY	0	0	194.14	
194.16	07966	SPRING VALLEY CLINIC	0	0	194.16	
194.17	07967	OGLESBY MP OB	0	0	194.17	
194.18	07968	FAMILY HEALTH CENTER	0	0	194.18	
194.19	07969	GRANVILLE CLINIC	0	0	194.19	
194.20	07970	PARATRANSIT	0	168,790	194.20	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.21	07971	OCCUPATIONAL HEALTH	0	586,906	194.21
194.24	07974	SURGICAL ASSOCIATES	0	193	194.24
194.27	07977	MIDTOWN	0	0	194.27
194.28	07978	PAIN CLINIC	0	212,763	194.28
194.30	07980	WHC-PTON	0	0	194.30
194.31	07981	CFH	0	0	194.31
194.32	07982	PFS	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,010,466	74,830,957	200.00

RECLASSIFICATIONS

Provider CCN: 14-0143

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

Worksheet A-6

Date/Time Prepared:
4/28/2021 3:00 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	B - DIETARY RECLASS					1.00
	CAFETERIA	11.00	640,690	320,035		
	TOTALS		640,690	320,035		
1.00	C - LAUNDRY SALARIES					1.00
	LAUNDRY & LINEN SERVICE	8.00	46,724	0		
	TOTALS		46,724	0		
1.00	D - DEPRECIATION FOR OFF CAMPUS CLINICS					1.00
	CLINIC	90.00	0	1,311,470		
	TOTALS		0	1,311,470		
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
1.00	E - AUDIOLOGY COSTS					1.00
	AUDIOLOGY	76.01	0	183,095		
	TOTALS		0	183,095		
1.00	F - INTEREST EXPENSE ON EQUIPMENT					1.00
	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	141,293		
	ADMINISTRATIVE & GENERAL	5.00	0	10,279		
2.00			0	948,225	2.00	
3.00			0	1,099,797	3.00	
1.00	G - PARATRANSIT COSTS					1.00
	PARATRANSIT	194.20	131,281	37,509		
	TOTALS		131,281	37,509		
1.00	H - LABOR AND DELIVERY SALARIES					1.00
	DELIVERY ROOM & LABOR ROOM	52.00	80,975	0		
	TOTALS		80,975	0		
1.00	I - TO RECLASS EMPLOYED HOSPITALIST					1.00
	ADULTS & PEDIATRICS	30.00	847,604	0		
	TOTALS		847,604	0		
500.00	Grand Total: Increases		1,747,274	2,951,906	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0143

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

Worksheet A-6

Date/Time Prepared:
4/28/2021 3:00 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	B - DIETARY RECLASS					
1.00	DIETARY	10.00	640,690	320,035	0	1.00
	TOTALS		640,690	320,035		
	C - LAUNDRY SALARIES					
1.00	HOUSEKEEPING	9.00	46,724	0	0	1.00
	TOTALS		46,724	0		
	D - DEPRECIATION FOR OFF CAMPUS CLINICS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,311,470	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
	TOTALS		0	1,311,470		
	E - AUDIOLOGY COSTS					
1.00	CLINIC	90.00	0	183,095	0	1.00
	TOTALS		0	183,095		
	F - INTEREST EXPENSE ON EQUIPMENT					
1.00	INTEREST EXPENSE	113.00	0	1,099,797	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
	TOTALS		0	1,099,797		
	G - PARATRANSIT COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	131,281	37,509	0	1.00
	TOTALS		131,281	37,509		
	H - LABOR AND DELIVERY SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	80,975	0	0	1.00
	TOTALS		80,975	0		
	I - TO RECLASS EMPLOYED HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	0	847,604	0	1.00
	TOTALS		0	847,604		
500.00	Grand Total: Decreases		899,670	3,799,510		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,841,557	0	0	0	0	1.00
2.00	Land Improvements	3,306,546	56,800	0	56,800	121,242	2.00
3.00	Buildings and Fixtures	73,793,002	1,917,634	0	1,917,634	159,479	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	33,057,141	1,601,386	0	1,601,386	1,283,153	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	112,998,246	3,575,820	0	3,575,820	1,563,874	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	112,998,246	3,575,820	0	3,575,820	1,563,874	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,841,557	0				1.00
2.00	Land Improvements	3,242,104	0				2.00
3.00	Buildings and Fixtures	75,551,157	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	33,375,374	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	115,010,192	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	115,010,192	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/28/2021 3:00 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	NEW CAP REL COSTS-BLDG & FIXT	3,654,337	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	450	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,681,698	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	6,336,485	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	NEW CAP REL COSTS-BLDG & FIXT	0	3,654,337				1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	450				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,681,698				2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	6,336,485				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	80,551,523	0	80,551,523	0.700386	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.009419	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	33,364,695	0	33,364,695	0.290102	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000093	0	2.01
3.00	Total (sum of lines 1-2)	115,010,192	0	115,010,192	0.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,342,867	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	450	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,685,407	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	57	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,028,781	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	916,983	0	0	0	3,259,850	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	450	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	141,293	0	0	0	2,826,700	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	57	2.01
3.00	Total (sum of lines 1-2)	1,058,276	0	0	0	6,087,057	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-31,242	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)			OLD CAP REL COSTS-BLDG & FIXT		1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)			OLD CAP REL COSTS-MVBLE EQUIP		2.01	0	2.01
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)	B	-1,797	ADMINISTRATIVE & GENERAL		5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,800	OPERATION OF PLANT		7.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-11,109,306				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	-75,690				0	12.00
13.00	Laundry and linen service		0			0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-219,159	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	B	-193,662	DRUGS CHARGED TO PATIENTS		73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,021	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines		0			0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF		114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT		0	OLD CAP REL COSTS-BLDG & FIXT		1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP		0	OLD CAP REL COSTS-MVBLE EQUIP		2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:
4/28/2021 3:00 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			
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	B	-2,030	PHYSICAL THERAPY	66.00	0	33.01
33.03	OB COMMISSIONS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.06	PATIENT PHONES	A	-9,404	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION	A	-4,799	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.10	MISC INCOME	B	-1,030	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PHYSICIAN RECRUITMENT	A	-134,370	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	EMPLOYEE HEALTH	A	-985,374	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.13
33.15	ADMIN COSTS FOR POB	A	1,011	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	A	-51,114	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.18
34.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34.00
35.00	HOSPITALIST RECEPTIONIST & OTHER EXP	A	-101,323	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	QUALITY REVENUE	B	-88,356	NURSING ADMINISTRATION	13.00	0	36.00
37.00	LEADERSHIP CONFERENCE SPOUSE COSTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,010,466				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: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:
4/28/2021 3:00 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	MANAGEMENT FEES	1,602,937	1,683,192 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000 2.00
3.00		2.01	OLD CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	57	0 3.00
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	8,508	0 4.00
5.00	0				1,611,502	1,687,192 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 reimbursement under title XVIII.

6.00	B		0.00	SRS OF MARY OF THE PRES	100.00	6.00
7.00	G	SMP HEALTH CORP	0.00	SMP HEALTH CORP	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				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: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:
4/28/2021 3:00 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	-80,255	0		1.00
2.00	-4,000	0		2.00
3.00	57	9		3.00
4.00	8,508	9		4.00
5.00	-75,690			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	RELIGIOUS COMMUNITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0143

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

Worksheet A-8-2

Date/Time Prepared:
4/28/2021 3:00 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	53.00	ANESTHESIOLOGY	1,787,000	1,276,141	510,859	239,400	595	1.00
2.00	91.00	EMERGENCY	636,675	321,839	314,836	179,000	4,344	2.00
3.00	43.00	NURSERY	112,543	112,543	0	0	0	3.00
4.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	4.00
5.00	16.00	MEDICAL RECORDS & LIBRARY	6,000	0	6,000	211,500	100	5.00
6.00	31.00	INTENSIVE CARE UNIT	9,600	9,600	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	870,324	860,477	9,847	211,500	54	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	90.00	CLINIC	7,815,713	7,815,713	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	266,260	266,260	0	0	0	10.00
200.00			11,539,115	10,662,573	876,542		5,613	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	53.00	ANESTHESIOLOGY	68,482	3,424	0	0	0	1.00
2.00	91.00	EMERGENCY	373,835	18,692	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	65,075	3,254	0	0	0	4.00
5.00	16.00	MEDICAL RECORDS & LIBRARY	10,168	508	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	5,491	275	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
200.00			523,051	26,153	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	53.00	ANESTHESIOLOGY	0	68,482	442,377	1,718,518		1.00
2.00	91.00	EMERGENCY	0	373,835	0	321,839		2.00
3.00	43.00	NURSERY	0	0	0	112,543		3.00
4.00	60.00	LABORATORY	0	65,075	0	0		4.00
5.00	16.00	MEDICAL RECORDS & LIBRARY	0	10,168	0	0		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	9,600		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	5,491	4,356	864,833		7.00
8.00	0.00		0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	7,815,713		9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	266,260		10.00
200.00			0	523,051	446,733	11,109,306		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,259,850	3,259,850				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	450	0	450			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,826,700			2,826,700		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	57			0	57	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,133,485	11,302	2	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,608,116	1,156,562	161	676,372	57	5.00
7.00	00700	OPERATION OF PLANT	2,080,576	306,589	42	9,033	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	212,010	8,114	1	0	0	8.00
9.00	00900	HOUSEKEEPING	833,756	32,383	4	13,742	0	9.00
10.00	01000	DIETARY	301,210	80,543	11	21,760	0	10.00
11.00	01100	CAFETERIA	741,566	27,692	4	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,164,677	27,795	4	2,902	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,884,534	42,867	6	23,957	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,274,882	242,426	33	110,493	0	30.00
31.00	03100	INTENSIVE CARE UNIT	773,403	52,064	7	45,981	0	31.00
43.00	04300	NURSERY	87,505	12,477	2	30,202	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,053,722	280,797	39	489,845	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,636	6,284	1	23,322	0	52.00
53.00	05300	ANESTHESIOLOGY	238,743	4,711	1	23,887	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,273,892	81,902	11	567,705	0	54.00
54.01	05402	NUCLEAR MEDICINE	186,590	21,439	3	97,873	0	54.01
57.00	05700	CT SCAN	539,875	6,642	1	70,474	0	57.00
60.00	06000	LABORATORY	3,667,977	39,945	6	37,996	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	216,130	2,391	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	526,334	15,941	2	15,070	0	65.00
66.00	06600	PHYSICAL THERAPY	1,450,206	106,856	15	4,627	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,070	399	0	1,193	0	67.00
68.00	06800	SPEECH PATHOLOGY	73,576	1,798	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	267,157	1,349	0	7,591	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	135,684	13,611	2	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	283,623	75,577	10	44,384	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,164,898	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,580,056	25,179	3	35,594	0	73.00
76.00	03020	SONOGRAPHY	560,395	5,467	1	3,865	0	76.00
76.01	03040	AUDIOLOGY	183,095	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	201,949	15,236	2	5,175	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	13,097,239	184,252	25	347,244	0	90.00
91.00	09100	EMERGENCY	1,860,039	100,173	14	100,064	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	690,851	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,092,881	9,953	1	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,111,395	3,000,716	414	2,810,351	57	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,642	2	0	0	190.00
194.00	07950	CONGREGATE LIVING	39,632	0	0	0	0	194.00
194.01	07951	OTHER	0	135,642	19	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	70,150	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	80,216	11	0	0	194.04
194.05	07955	SPECIALTY CLINICS	1,822	0	0	869	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	639,306	29,634	4	14,568	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	168,790	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	586,906	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	193	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	912	0	194.27
194.28	07978	PAIN CLINIC	212,763	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	74,830,957	3,259,850	450	2,826,700	57	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,144,789					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	662,632	13,103,900	13,103,900			5.00
7.00	00700	OPERATION OF PLANT	114,775	2,511,015	533,058	3,044,073		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,237	229,362	48,691	13,834	291,887	8.00
9.00	00900	HOUSEKEEPING	113,086	992,971	210,796	55,212		9.00
10.00	01000	DIETARY	39,713	443,237	94,094	137,325		10.00
11.00	01100	CAFETERIA	126,658	895,920	190,193	47,215		11.00
13.00	01300	NURSING ADMINISTRATION	229,177	1,424,555	302,416	47,389		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	304,953	2,256,317	478,989	73,088		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	734,865	4,362,699	926,149	413,333	189,822	30.00
31.00	03100	INTENSIVE CARE UNIT	146,023	1,017,478	215,998	88,768	15,558	31.00
43.00	04300	NURSERY	11,774	141,960	30,136	21,273	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	408,787	7,233,190	1,535,519	478,755	30,940	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,526	547,769	116,285	10,715	0	52.00
53.00	05300	ANESTHESIOLOGY	0	267,342	56,753	8,032	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,168	3,087,678	655,477	139,642	19,469	54.00
54.01	05402	NUCLEAR MEDICINE	36,887	342,792	72,771	36,553	0	54.01
57.00	05700	CT SCAN	30,778	647,770	137,514	11,325	3,882	57.00
60.00	06000	LABORATORY	206,175	3,952,099	838,983	68,105	146	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	218,521	46,389	4,077	0	63.00
65.00	06500	RESPIRATORY THERAPY	82,662	640,009	135,866	27,179	570	65.00
66.00	06600	PHYSICAL THERAPY	266,737	1,828,441	388,156	182,188	15,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,101	167,763	35,614	679	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,921	89,295	18,956	3,066	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,562	297,659	63,189	2,300	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,051	161,348	34,252	23,207	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,996	412,590	87,588	128,857	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,164,898	459,582	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,088	2,796,920	593,753	42,929	0	73.00
76.00	03020	SONOGRAPHY	37,503	607,231	128,908	9,321	0	76.00
76.01	03040	AUDIOLOGY	0	183,095	38,869	0	0	76.01
76.02	03160	CARDIAC REHAB	35,508	257,870	54,743	25,977	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,569,900	15,198,660	3,226,483	314,147	0	90.00
91.00	09100	EMERGENCY	199,047	2,259,337	479,630	170,794	15,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	690,851	146,659	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	95,529	1,198,364	254,398	16,970	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,939,819	72,630,906	12,636,857	2,602,255	291,503	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,644	2,896	23,259	0	190.00
194.00	07950	CONGREGATE LIVING	0	39,632	8,413	0	0	194.00
194.01	07951	OTHER	7,509	143,170	30,393	231,267	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	10,505	80,655	17,122	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	80,227	17,031	136,767	0	194.04
194.05	07955	SPECIALTY CLINICS	0	2,691	571	0	384	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	47,850	731,362	155,259	50,525	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	25,953	194,743	41,342	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	87,997	674,903	143,274	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	193	41	0	0	194.24
194.27	07977	MIDTOWN	0	912	194	0	0	194.27
194.28	07978	PAIN CLINIC	25,156	237,919	50,507	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	6,144,789	74,830,957	13,103,900	3,044,073	291,887	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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4/28/2021 3:00 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,258,979					9.00
10.00	01000	DIETARY	62,524	737,180				10.00
11.00	01100	CAFETERIA	49,860	0	1,183,188			11.00
13.00	01300	NURSING ADMINISTRATION	37,491	0	34,459	1,846,310		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,749	0	146,173	0	3,030,316	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	481,146	483,875	237,694	790,663	165,395	30.00
31.00	03100	INTENSIVE CARE UNIT	61,992	92,984	49,743	165,520	22,347	31.00
43.00	04300	NURSERY	5,697	0	8,615	28,664	7,783	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	100,221	0	167,571	557,392	454,811	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,122	0	23,390	77,860	13,748	52.00
53.00	05300	ANESTHESIOLOGY	1,033	0	0	0	87,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,255	0	72,160	0	148,804	54.00
54.01	05402	NUCLEAR MEDICINE	2,244	0	11,533	0	107,689	54.01
57.00	05700	CT SCAN	2,244	0	6,577	0	223,732	57.00
60.00	06000	LABORATORY	25,092	0	96,847	0	548,786	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,657	0	0	0	5,356	63.00
65.00	06500	RESPIRATORY THERAPY	6,052	0	31,402	0	39,466	65.00
66.00	06600	PHYSICAL THERAPY	12,487	0	0	0	126,396	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	11,948	67.00
68.00	06800	SPEECH PATHOLOGY	2,244	0	0	0	4,796	68.00
69.00	06900	ELECTROCARDIOLOGY	3,897	0	8,337	0	80,894	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	886	0	5,882	0	13,124	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,052	0	6,531	0	149,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	53,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,092	0	42,657	0	95,932	73.00
76.00	03020	SONOGRAPHY	2,244	0	11,255	2,244	103,033	76.00
76.01	03040	AUDIOLOGY	2,244	0	0	0	4,684	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	15,293	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	86,379	0	82,698	90.00
91.00	09100	EMERGENCY	25,092	0	67,992	226,211	137,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	9,243	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	31,680	0	24,686	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,056,617	576,859	1,146,877	1,846,310	2,738,029	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,244	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	22,523	194.00
194.01	07951	OTHER	0	160,321	4,029	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	44,903	194.02
194.03	07953	MANAGED CARE	0	0	2,964	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	200,118	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	8,853	194.05
194.08	07958	ENT	0	0	0	0	17,156	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	8,632	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	48,302	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	28,548	194.13
194.14	07964	HENRY	0	0	0	0	1,968	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	964	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	2,856	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	26,573	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	4,001	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	29,318	0	4,895	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	40,207	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	3,251	194.28
194.30	07980	WHC-PTON	0	0	0	0	7,732	194.30
194.31	07981	CFH	0	0	0	0	20,923	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,258,979	737,180	1,183,188	1,846,310	3,030,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	8,050,776	0	8,050,776	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,730,388	0	1,730,388	31.00
43.00	04300	NURSERY	0	244,128	0	244,128	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	10,558,399	0	10,558,399	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	814,889	0	814,889	52.00
53.00	05300	ANESTHESIOLOGY	0	420,383	0	420,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,160,485	0	4,160,485	54.00
54.01	05402	NUCLEAR MEDICINE	0	573,582	0	573,582	54.01
57.00	05700	CT SCAN	0	1,033,044	0	1,033,044	57.00
60.00	06000	LABORATORY	0	5,530,058	0	5,530,058	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	277,000	0	277,000	63.00
65.00	06500	RESPIRATORY THERAPY	0	880,544	0	880,544	65.00
66.00	06600	PHYSICAL THERAPY	0	2,553,226	0	2,553,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	216,004	0	216,004	67.00
68.00	06800	SPEECH PATHOLOGY	0	118,357	0	118,357	68.00
69.00	06900	ELECTROCARDIOLOGY	0	456,276	0	456,276	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	238,699	0	238,699	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	790,923	0	790,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,678,094	0	2,678,094	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,597,283	0	3,597,283	73.00
76.00	03020	SONOGRAPHY	0	861,992	0	861,992	76.00
76.01	03040	AUDIOLOGY	0	228,892	0	228,892	76.01
76.02	03160	CARDIAC REHAB	0	353,883	0	353,883	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	18,908,367	0	18,908,367	90.00
91.00	09100	EMERGENCY	0	3,381,857	0	3,381,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	846,753	0	846,753	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,526,098	0	1,526,098	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	71,030,380	0	71,030,380	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,043	0	42,043	190.00
194.00	07950	CONGREGATE LIVING	0	70,568	0	70,568	194.00
194.01	07951	OTHER	0	569,180	0	569,180	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	44,903	0	44,903	194.02
194.03	07953	MANAGED CARE	0	100,741	0	100,741	194.03
194.04	07954	RENTAL AREA/PPOS	0	434,143	0	434,143	194.04
194.05	07955	SPECIALTY CLINICS	0	12,499	0	12,499	194.05
194.08	07958	ENT	0	17,156	0	17,156	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	945,778	0	945,778	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	48,302	0	48,302	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	28,548	0	28,548	194.13
194.14	07964	HENRY	0	1,968	0	1,968	194.14
194.16	07966	SPRING VALLEY CLINIC	0	964	0	964	194.16
194.17	07967	OGLESBY MP OB	0	2,856	0	2,856	194.17
194.18	07968	FAMILY HEALTH CENTER	0	26,573	0	26,573	194.18

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	4,001	0	4,001		194.19
194.20	07970	PARATRANSIT	0	236,085	0	236,085		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	852,390	0	852,390		194.21
194.24	07974	SURGICAL ASSOCIATES	0	234	0	234		194.24
194.27	07977	MIDTOWN	0	41,313	0	41,313		194.27
194.28	07978	PAIN CLINIC	0	291,677	0	291,677		194.28
194.30	07980	WHC-PTON	0	7,732	0	7,732		194.30
194.31	07981	CFH	0	20,923	0	20,923		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	74,830,957	0	74,830,957		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP		OLD MVBLE EQUIP
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,302	2	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,509	1,156,562	161	676,372	57	5.00
7.00	00700	OPERATION OF PLANT	1,936	306,589	42	9,033	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,114	1	0	0	8.00
9.00	00900	HOUSEKEEPING	2,040	32,383	4	13,742	0	9.00
10.00	01000	DIETARY	0	80,543	11	21,760	0	10.00
11.00	01100	CAFETERIA	0	27,692	4	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,795	4	2,902	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,524	42,867	6	23,957	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	52,803	242,426	33	110,493	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,202	52,064	7	45,981	0	31.00
43.00	04300	NURSERY	0	12,477	2	30,202	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	157,086	280,797	39	489,845	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,284	1	23,322	0	52.00
53.00	05300	ANESTHESIOLOGY	31,668	4,711	1	23,887	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,336	81,902	11	567,705	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	21,439	3	97,873	0	54.01
57.00	05700	CT SCAN	134,616	6,642	1	70,474	0	57.00
60.00	06000	LABORATORY	0	39,945	6	37,996	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,391	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,816	15,941	2	15,070	0	65.00
66.00	06600	PHYSICAL THERAPY	4,800	106,856	15	4,627	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	399	0	1,193	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,798	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,349	0	7,591	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,611	2	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,577	10	44,384	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	1,482	25,179	3	35,594	0	73.00
76.00	03020	SONOGRAPHY	0	5,467	1	3,865	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	15,236	2	5,175	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,508	184,252	25	347,244	0	90.00
91.00	09100	EMERGENCY	9,696	100,173	14	100,064	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	24,102	9,953	1	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	468,124	3,000,716	414	2,810,351	57	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,642	2	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00
194.01	07951	OTHER	0	135,642	19	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	80,216	11	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	869	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	29,634	4	14,568	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	912	0	194.27
194.28	07978	PAIN CLINIC	2,664	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	470,788	3,259,850	450	2,826,700	57	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,304	11,304				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,848,661	1,220	1,849,881			5.00
7.00	00700	OPERATION OF PLANT	317,600	211	75,253	393,064		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,115	17	6,874	1,786	16,792	8.00
9.00	00900	HOUSEKEEPING	48,169	208	29,758	7,129	0	9.00
10.00	01000	DIETARY	102,314	73	13,283	17,732	0	10.00
11.00	01100	CAFETERIA	27,696	233	26,850	6,097	0	11.00
13.00	01300	NURSING ADMINISTRATION	30,701	422	42,692	6,119	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,354	561	67,620	9,437	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	405,755	1,353	130,746	53,371	10,921	30.00
31.00	03100	INTENSIVE CARE UNIT	107,254	269	30,493	11,462	895	31.00
43.00	04300	NURSERY	42,681	22	4,254	2,747	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	927,767	753	216,771	61,820	1,780	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,607	135	16,416	1,384	0	52.00
53.00	05300	ANESTHESIOLOGY	60,267	0	8,012	1,037	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,954	302	92,535	18,031	1,120	54.00
54.01	05402	NUCLEAR MEDICINE	119,315	68	10,273	4,720	0	54.01
57.00	05700	CT SCAN	211,733	57	19,413	1,462	223	57.00
60.00	06000	LABORATORY	77,947	380	118,440	8,794	8	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,391	0	6,549	526	0	63.00
65.00	06500	RESPIRATORY THERAPY	40,829	152	19,180	3,509	33	65.00
66.00	06600	PHYSICAL THERAPY	116,298	491	54,797	23,525	895	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,592	50	5,028	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,798	26	2,676	396	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,940	40	8,921	297	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,613	22	4,835	2,997	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,971	17	12,365	16,639	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	64,880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,258	287	83,821	5,543	0	73.00
76.00	03020	SONOGRAPHY	9,333	69	18,198	1,204	0	76.00
76.01	03040	AUDIOLOGY	0	0	5,487	0	0	76.01
76.02	03160	CARDIAC REHAB	20,413	65	7,728	3,354	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	533,029	2,882	455,472	40,564	0	90.00
91.00	09100	EMERGENCY	209,947	366	67,710	22,054	895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	20,704	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	34,056	176	35,914	2,191	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,279,662	10,927	1,783,948	336,015	16,770	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,644	0	409	3,003	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	1,188	0	0	194.00
194.01	07951	OTHER	135,661	14	4,291	29,862	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	19	2,417	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	80,227	0	2,404	17,660	0	194.04
194.05	07955	SPECIALTY CLINICS	869	0	81	0	22	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	44,206	88	21,918	6,524	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	48	5,836	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	0	162	20,226	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	6	0	0	194.24
194.27	07977	MIDTOWN	912	0	27	0	0	194.27
194.28	07978	PAIN CLINIC	2,664	46	7,130	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	6,557,845	11,304	1,849,881	393,064	16,792	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	85,264					9.00
10.00	01000	DIETARY	4,234	137,636				10.00
11.00	01100	CAFETERIA	3,377	0	64,253			11.00
13.00	01300	NURSING ADMINISTRATION	2,539	0	1,871	84,344		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,130	0	7,938	0	159,040	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,587	90,342	12,910	36,120	8,682	30.00
31.00	03100	INTENSIVE CARE UNIT	4,198	17,361	2,701	7,561	1,173	31.00
43.00	04300	NURSERY	386	0	468	1,309	409	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,787	0	9,100	25,463	23,873	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,701	0	1,270	3,557	722	52.00
53.00	05300	ANESTHESIOLOGY	70	0	0	0	4,578	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,523	0	3,919	0	7,811	54.00
54.01	05402	NUCLEAR MEDICINE	152	0	626	0	5,653	54.01
57.00	05700	CT SCAN	152	0	357	0	11,744	57.00
60.00	06000	LABORATORY	1,699	0	5,259	0	28,784	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	180	0	0	0	281	63.00
65.00	06500	RESPIRATORY THERAPY	410	0	1,705	0	2,072	65.00
66.00	06600	PHYSICAL THERAPY	846	0	0	0	6,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	627	67.00
68.00	06800	SPEECH PATHOLOGY	152	0	0	0	252	68.00
69.00	06900	ELECTROCARDIOLOGY	264	0	453	0	4,246	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60	0	319	0	689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	410	0	355	0	7,837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,699	0	2,316	0	5,035	73.00
76.00	03020	SONOGRAPHY	152	0	611	0	5,408	76.00
76.01	03040	AUDIOLOGY	152	0	0	0	246	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	803	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	4,691	0	4,341	90.00
91.00	09100	EMERGENCY	1,699	0	3,692	10,334	7,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	485	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	1,720	0	1,296	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,559	107,703	62,281	84,344	143,699	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	152	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	1,182	194.00
194.01	07951	OTHER	0	29,933	219	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	2,357	194.02
194.03	07953	MANAGED CARE	0	0	161	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	13,553	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	465	194.05
194.08	07958	ENT	0	0	0	0	900	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	453	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,535	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	1,498	194.13
194.14	07964	HENRY	0	0	0	0	103	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	51	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	150	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	1,395	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	210	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	1,592	0	257	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	2,110	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	171	194.28
194.30	07980	WHC-PTON	0	0	0	0	406	194.30
194.31	07981	CFH	0	0	0	0	1,098	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	85,264	137,636	64,253	84,344	159,040	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	782,787	0	782,787	30.00
31.00	03100	INTENSIVE CARE UNIT	0	183,367	0	183,367	31.00
43.00	04300	NURSERY	0	52,276	0	52,276	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,274,114	0	1,274,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	54,792	0	54,792	52.00
53.00	05300	ANESTHESIOLOGY	0	73,964	0	73,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	786,195	0	786,195	54.00
54.01	05402	NUCLEAR MEDICINE	0	140,807	0	140,807	54.01
57.00	05700	CT SCAN	0	245,141	0	245,141	57.00
60.00	06000	LABORATORY	0	241,311	0	241,311	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,927	0	9,927	63.00
65.00	06500	RESPIRATORY THERAPY	0	67,890	0	67,890	65.00
66.00	06600	PHYSICAL THERAPY	0	203,486	0	203,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,385	0	7,385	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,300	0	5,300	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,161	0	23,161	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,535	0	22,535	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	157,594	0	157,594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,694	0	67,694	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	160,959	0	160,959	73.00
76.00	03020	SONOGRAPHY	0	34,975	0	34,975	76.00
76.01	03040	AUDIOLOGY	0	5,885	0	5,885	76.01
76.02	03160	CARDIAC REHAB	0	32,363	0	32,363	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,040,979	0	1,040,979	90.00
91.00	09100	EMERGENCY	0	323,901	0	323,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	21,189	0	21,189	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	75,353	0	75,353	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,095,330	0	6,095,330	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,208	0	17,208	190.00
194.00	07950	CONGREGATE LIVING	0	2,370	0	2,370	194.00
194.01	07951	OTHER	0	199,980	0	199,980	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	2,357	0	2,357	194.02
194.03	07953	MANAGED CARE	0	2,597	0	2,597	194.03
194.04	07954	RENTAL AREA/PPOS	0	113,844	0	113,844	194.04
194.05	07955	SPECIALTY CLINICS	0	1,437	0	1,437	194.05
194.08	07958	ENT	0	900	0	900	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	73,189	0	73,189	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,535	0	2,535	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	1,498	0	1,498	194.13
194.14	07964	HENRY	0	103	0	103	194.14
194.16	07966	SPRING VALLEY CLINIC	0	51	0	51	194.16
194.17	07967	OGLESBY MP OB	0	150	0	150	194.17
194.18	07968	FAMILY HEALTH CENTER	0	1,395	0	1,395	194.18

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	210	0	210		194.19
194.20	07970	PARATRANSIT	0	5,884	0	5,884		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	22,237	0	22,237		194.21
194.24	07974	SURGICAL ASSOCIATES	0	6	0	6		194.24
194.27	07977	MIDTOWN	0	3,049	0	3,049		194.27
194.28	07978	PAIN CLINIC	0	10,011	0	10,011		194.28
194.30	07980	WHC-PTON	0	406	0	406		194.30
194.31	07981	CFH	0	1,098	0	1,098		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,557,845	0	6,557,845		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 3:00 pm

		Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	319,011					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	319,011				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,681,696			2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	95		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	0	31,082,886	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	113,182	113,182	641,673	95	3,351,875	5.00
7.00	00700	OPERATION OF PLANT	30,003	30,003	8,570	0	580,581	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	46,724	8.00
9.00	00900	HOUSEKEEPING	3,169	3,169	13,037	0	572,037	9.00
10.00	01000	DIETARY	7,882	7,882	20,644	0	200,883	10.00
11.00	01100	CAFETERIA	2,710	2,710	0	0	640,690	11.00
13.00	01300	NURSING ADMINISTRATION	2,720	2,720	2,753	0	1,159,277	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	22,728	0	1,542,581	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,724	23,724	104,825	0	3,717,259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	43,622	0	738,645	31.00
43.00	04300	NURSERY	1,221	1,221	28,653	0	59,560	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,479	27,479	464,717	0	2,067,819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	22,126	0	371,927	52.00
53.00	05300	ANESTHESIOLOGY	461	461	22,662	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	538,583	0	830,434	54.00
54.01	05402	NUCLEAR MEDICINE	2,098	2,098	92,852	0	186,590	54.01
57.00	05700	CT SCAN	650	650	66,859	0	155,687	57.00
60.00	06000	LABORATORY	3,909	3,909	36,047	0	1,042,922	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,560	1,560	14,297	0	418,137	65.00
66.00	06600	PHYSICAL THERAPY	10,457	10,457	4,390	0	1,349,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	39	39	1,132	0	137,087	67.00
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	70,416	68.00
69.00	06900	ELECTROCARDIOLOGY	132	132	7,202	0	109,072	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332	1,332	0	0	60,958	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,396	7,396	42,107	0	45,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,464	2,464	33,768	0	789,561	73.00
76.00	03020	SONOGRAPHY	535	535	3,667	0	189,706	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	1,491	1,491	4,910	0	179,615	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	18,031	18,031	329,431	0	7,941,151	90.00
91.00	09100	EMERGENCY	9,803	9,803	94,931	0	1,006,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	974	974	0	0	483,225	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,652	293,652	2,666,186	95	30,046,062	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00
194.01	07951	OTHER	13,274	13,274	0	0	37,982	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	53,138	194.03
194.04	07954	RENTAL AREA/PPOS	7,850	7,850	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	824	0	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	13,821	0	242,047	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	131,281	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	445,127	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	865	0	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	127,249	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,259,850	450	2,826,700	57	6,144,789	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.218613	0.001411	1.054072	0.600000	0.197690	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					11,304	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000364	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: 14-0143

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,103,900	61,727,057				5.00
7.00	00700	OPERATION OF PLANT	0	2,511,015	174,720			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	229,362	794	265,812		8.00
9.00	00900	HOUSEKEEPING	0	992,971	3,169	0	42,648	9.00
10.00	01000	DIETARY	0	443,237	7,882	0	2,118	10.00
11.00	01100	CAFETERIA	0	895,920	2,710	0	1,689	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,424,555	2,720	0	1,270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,256,317	4,195	0	2,566	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,362,699	23,724	172,865	16,299	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,017,478	5,095	14,168	2,100	31.00
43.00	04300	NURSERY	0	141,960	1,221	0	193	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,233,190	27,479	28,176	3,395	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	547,769	615	0	851	52.00
53.00	05300	ANESTHESIOLOGY	0	267,342	461	0	35	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,087,678	8,015	17,730	1,262	54.00
54.01	05402	NUCLEAR MEDICINE	0	342,792	2,098	0	76	54.01
57.00	05700	CT SCAN	0	647,770	650	3,535	76	57.00
60.00	06000	LABORATORY	0	3,952,099	3,909	133	850	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	218,521	234	0	90	63.00
65.00	06500	RESPIRATORY THERAPY	0	640,009	1,560	519	205	65.00
66.00	06600	PHYSICAL THERAPY	0	1,828,441	10,457	14,168	423	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	167,763	39	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	89,295	176	0	76	68.00
69.00	06900	ELECTROCARDIOLOGY	0	297,659	132	0	132	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	161,348	1,332	0	30	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	412,590	7,396	0	205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,164,898	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,796,920	2,464	0	850	73.00
76.00	03020	SONOGRAPHY	0	607,231	535	0	76	76.00
76.01	03040	AUDIOLOGY	0	183,095	0	0	76	76.01
76.02	03160	CARDIAC REHAB	0	257,870	1,491	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	15,198,660	18,031	0	0	90.00
91.00	09100	EMERGENCY	0	2,259,337	9,803	14,168	850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	690,851	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,198,364	974	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,103,900	59,527,006	149,361	265,462	35,793	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,644	1,335	0	76	190.00
194.00	07950	CONGREGATE LIVING	0	39,632	0	0	0	194.00
194.01	07951	OTHER	0	143,170	13,274	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	80,655	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	80,227	7,850	0	6,779	194.04
194.05	07955	SPECIALTY CLINICS	0	2,691	0	350	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	731,362	2,900	0	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
194.20	07970	PARATRANSIT	0	194,743	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	674,903	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	193	0	0	0	194.24
194.27	07977	MIDTOWN	0	912	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	237,919	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)		13,103,900	3,044,073	291,887	1,258,979	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.212288	17.422579	1.098096	29.520235	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,849,881	393,064	16,792	85,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.029969	2.249679	0.063172	1.999250	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: 14-0143

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	20,264					10.00
11.00	01100	CAFETERIA	0	25,546				11.00
13.00	01300	NURSING ADMINISTRATION	0	744	249,272			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,156	0	240,272,063		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,301	5,132	106,748	13,114,075	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,556	1,074	22,347	1,771,869	0	31.00
43.00	04300	NURSERY	0	186	3,870	617,150	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,618	75,254	36,061,776	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	505	10,512	1,090,111	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,915,854	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,558	0	11,798,597	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	249	0	8,538,641	0	54.01
57.00	05700	CT SCAN	0	142	0	17,739,646	0	57.00
60.00	06000	LABORATORY	0	2,091	0	43,512,603	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	424,697	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	678	0	3,129,240	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,021,850	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	947,386	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	380,240	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	180	0	6,414,069	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	127	0	1,040,563	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	141	0	11,838,355	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,251,063	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	921	0	7,606,415	0	73.00
76.00	03020	SONOGRAPHY	0	243	0	8,169,404	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	371,377	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,212,544	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,865	0	6,557,053	0	90.00
91.00	09100	EMERGENCY	0	1,468	30,541	10,881,964	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	732,895	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	684	0	1,957,327	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,857	24,762	249,272	217,096,764	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	1,785,809	0	194.00
194.01	07951	OTHER	4,407	87	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	3,560,300	0	194.02
194.03	07953	MANAGED CARE	0	64	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	701,988	0	194.05
194.08	07958	ENT	0	0	0	1,360,270	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	684,404	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	3,829,845	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	2,263,592	0	194.13
194.14	07964	HENRY	0	0	0	156,038	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	76,415	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	226,442	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	2,106,927	0	194.18

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	317,275	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	633	0	388,142	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	3,188,009	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	257,774	0	194.28
194.30	07980	WHC-PTON	0	0	0	613,104	0	194.30
194.31	07981	CFH	0	0	0	1,658,965	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	737,180	1,183,188	1,846,310	3,030,316	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.378800	46.315979	7.406809	0.012612	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	137,636	64,253	84,344	159,040	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.792144	2.515188	0.338361	0.000662	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,050,776		8,050,776	4,356	8,055,132	30.00
31.00	03100	INTENSIVE CARE UNIT	1,730,388		1,730,388	0	1,730,388	31.00
43.00	04300	NURSERY	244,128		244,128	0	244,128	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,558,399		10,558,399	0	10,558,399	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,889		814,889	0	814,889	52.00
53.00	05300	ANESTHESIOLOGY	420,383		420,383	442,377	862,760	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,160,485		4,160,485	0	4,160,485	54.00
54.01	05402	NUCLEAR MEDICINE	573,582		573,582	0	573,582	54.01
57.00	05700	CT SCAN	1,033,044		1,033,044	0	1,033,044	57.00
60.00	06000	LABORATORY	5,530,058		5,530,058	0	5,530,058	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	277,000		277,000	0	277,000	63.00
65.00	06500	RESPIRATORY THERAPY	880,544	0	880,544	0	880,544	65.00
66.00	06600	PHYSICAL THERAPY	2,553,226	0	2,553,226	0	2,553,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,004	0	216,004	0	216,004	67.00
68.00	06800	SPEECH PATHOLOGY	118,357	0	118,357	0	118,357	68.00
69.00	06900	ELECTROCARDIOLOGY	456,276		456,276	0	456,276	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	238,699		238,699	0	238,699	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	790,923		790,923	0	790,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,678,094		2,678,094	0	2,678,094	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,597,283		3,597,283	0	3,597,283	73.00
76.00	03020	SONOGRAPHY	861,992		861,992	0	861,992	76.00
76.01	03040	AUDIOLOGY	228,892		228,892	0	228,892	76.01
76.02	03160	CARDIAC REHAB	353,883		353,883	0	353,883	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	18,908,367		18,908,367	0	18,908,367	90.00
91.00	09100	EMERGENCY	3,381,857		3,381,857	0	3,381,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,883,912		2,883,912	0	2,883,912	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	846,753		846,753	0	846,753	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,526,098		1,526,098		1,526,098	116.00
200.00		Subtotal (see instructions)	73,914,292	0	73,914,292	446,733	74,361,025	200.00
201.00		Less Observation Beds	2,883,912		2,883,912		2,883,912	201.00
202.00		Total (see instructions)	71,030,380	0	71,030,380	446,733	71,477,113	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 3:00 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	7,963,800		7,963,800			30.00
31.00	03100	INTENSIVE CARE UNIT	1,763,269		1,763,269			31.00
43.00	04300	NURSERY	610,866		610,866			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,157,782	27,614,182	35,771,964	0.295158	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	937,764	140,491	1,078,255	0.755748	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,287,637	4,564,221	6,851,858	0.061353	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,431,198	10,264,956	11,696,154	0.355714	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	388,082	8,130,135	8,518,217	0.067336	0.000000	54.01
57.00	05700	CT SCAN	2,310,601	15,333,140	17,643,741	0.058550	0.000000	57.00
60.00	06000	LABORATORY	7,646,286	35,633,487	43,279,773	0.127775	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	261,437	162,369	423,806	0.653601	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,134,736	985,097	3,119,833	0.282241	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	885,452	9,074,741	9,960,193	0.256343	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	146,951	794,613	941,564	0.229410	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	45,335	332,802	378,137	0.313000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,382,774	4,010,700	6,393,474	0.071366	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,614	1,026,682	1,030,296	0.231680	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,288,387	4,518,691	11,807,078	0.066987	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,811,449	439,614	4,251,063	0.629982	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,953,140	4,600,127	7,553,267	0.476255	0.000000	73.00
76.00	03020	SONOGRAPHY	1,117,807	7,005,414	8,123,221	0.106115	0.000000	76.00
76.01	03040	AUDIOLOGY	0	371,377	371,377	0.616333	0.000000	76.01
76.02	03160	CARDIAC REHAB	21,490	1,182,813	1,204,303	0.293849	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	81,000	6,432,862	6,513,862	2.902789	0.000000	90.00
91.00	09100	EMERGENCY	1,619,023	9,214,579	10,833,602	0.312164	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	993,424	4,111,016	5,104,440	0.564981	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	729,906	729,906	1.160085	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,953,711	1,953,711			116.00
200.00		Subtotal (see instructions)	57,243,304	158,627,726	215,871,030			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	57,243,304	158,627,726	215,871,030			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.295158			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.755748			52.00
53.00	05300	ANESTHESIOLOGY	0.125916			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.355714			54.00
54.01	05402	NUCLEAR MEDICINE	0.067336			54.01
57.00	05700	CT SCAN	0.058550			57.00
60.00	06000	LABORATORY	0.127775			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653601			63.00
65.00	06500	RESPIRATORY THERAPY	0.282241			65.00
66.00	06600	PHYSICAL THERAPY	0.256343			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229410			67.00
68.00	06800	SPEECH PATHOLOGY	0.313000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.071366			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.231680			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.066987			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629982			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476255			73.00
76.00	03020	SONOGRAPHY	0.106115			76.00
76.01	03040	AUDIOLOGY	0.616333			76.01
76.02	03160	CARDIAC REHAB	0.293849			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	2.902789			90.00
91.00	09100	EMERGENCY	0.312164			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564981			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.160085			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
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

Worksheet C
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

MCRIF32 - 16.9.172.5

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,963,800		7,963,800			30.00	
31.00	03100	INTENSIVE CARE UNIT	1,763,269		1,763,269			31.00	
43.00	04300	NURSERY	610,866		610,866			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,157,782	27,614,182	35,771,964	0.295158	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	937,764	140,491	1,078,255	0.755748	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,287,637	4,564,221	6,851,858	0.061353	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,431,198	10,264,956	11,696,154	0.355714	0.000000	54.00	
54.01	05402	NUCLEAR MEDICINE	388,082	8,130,135	8,518,217	0.067336	0.000000	54.01	
57.00	05700	CT SCAN	2,310,601	15,333,140	17,643,741	0.058550	0.000000	57.00	
60.00	06000	LABORATORY	7,646,286	35,633,487	43,279,773	0.127775	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	261,437	162,369	423,806	0.653601	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	2,134,736	985,097	3,119,833	0.282241	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	885,452	9,074,741	9,960,193	0.256343	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	146,951	794,613	941,564	0.229410	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	45,335	332,802	378,137	0.313000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,382,774	4,010,700	6,393,474	0.071366	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,614	1,026,682	1,030,296	0.231680	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,288,387	4,518,691	11,807,078	0.066987	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,811,449	439,614	4,251,063	0.629982	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,953,140	4,600,127	7,553,267	0.476255	0.000000	73.00	
76.00	03020	SONOGRAPHY	1,117,807	7,005,414	8,123,221	0.106115	0.000000	76.00	
76.01	03040	AUDIOLOGY	0	371,377	371,377	0.616333	0.000000	76.01	
76.02	03160	CARDIAC REHAB	21,490	1,182,813	1,204,303	0.293849	0.000000	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00	
90.00	09000	CLINIC	81,000	6,432,862	6,513,862	2.902789	0.000000	90.00	
91.00	09100	EMERGENCY	1,619,023	9,214,579	10,833,602	0.312164	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	993,424	4,111,016	5,104,440	0.564981	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	729,906	729,906	1.160085	0.000000	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	0	1,953,711	1,953,711			116.00	
200.00		Subtotal (see instructions)	57,243,304	158,627,726	215,871,030			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	57,243,304	158,627,726	215,871,030			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet C Part I Date/Time Prepared: 4/28/2021 3:00 pm
			Title XIX	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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.295158		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.755748		52.00
53.00	05300	ANESTHESIOLOGY	0.125916		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.355714		54.00
54.01	05402	NUCLEAR MEDICINE	0.067336		54.01
57.00	05700	CT SCAN	0.058550		57.00
60.00	06000	LABORATORY	0.127775		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653601		63.00
65.00	06500	RESPIRATORY THERAPY	0.282241		65.00
66.00	06600	PHYSICAL THERAPY	0.256343		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229410		67.00
68.00	06800	SPEECH PATHOLOGY	0.313000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.071366		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.231680		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.066987		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629982		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476255		73.00
76.00	03020	SONOGRAPHY	0.106115		76.00
76.01	03040	AUDIOLOGY	0.616333		76.01
76.02	03160	CARDIAC REHAB	0.293849		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	2.902789		90.00
91.00	09100	EMERGENCY	0.312164		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564981		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1.160085		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description			Title XIX		Hospital		PPS
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,558,399	1,274,114	9,284,285	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,889	54,792	760,097	0	0
53.00	05300	ANESTHESIOLOGY	420,383	73,964	346,419	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,160,485	786,195	3,374,290	0	0
54.01	05402	NUCLEAR MEDICINE	573,582	140,807	432,775	0	0
57.00	05700	CT SCAN	1,033,044	245,141	787,903	0	0
60.00	06000	LABORATORY	5,530,058	241,311	5,288,747	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	277,000	9,927	267,073	0	0
65.00	06500	RESPIRATORY THERAPY	880,544	67,890	812,654	0	0
66.00	06600	PHYSICAL THERAPY	2,553,226	203,486	2,349,740	0	0
67.00	06700	OCCUPATIONAL THERAPY	216,004	7,385	208,619	0	0
68.00	06800	SPEECH PATHOLOGY	118,357	5,300	113,057	0	0
69.00	06900	ELECTROCARDIOLOGY	456,276	23,161	433,115	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	238,699	22,535	216,164	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	790,923	157,594	633,329	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,678,094	67,694	2,610,400	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,597,283	160,959	3,436,324	0	0
76.00	03020	SONOGRAPHY	861,992	34,975	827,017	0	0
76.01	03040	AUDIOLOGY	228,892	5,885	223,007	0	0
76.02	03160	CARDIAC REHAB	353,883	32,363	321,520	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	18,908,367	1,040,979	17,867,388	0	0
91.00	09100	EMERGENCY	3,381,857	323,901	3,057,956	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,883,912	280,256	2,603,656	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	846,753	21,189	825,564	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,526,098	75,353	1,450,745	0	0
200.00		Subtotal (sum of lines 50 thru 199)	63,889,000	5,357,156	58,531,844	0	0
201.00		Less Observation Beds	2,883,912	280,256	2,603,656	0	0
202.00		Total (line 200 minus line 201)	61,005,088	5,076,900	55,928,188	0	0

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

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)				
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,558,399	35,771,964	0.295158			50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,889	1,078,255	0.755748			52.00	
53.00	05300	ANESTHESIOLOGY	420,383	6,851,858	0.061353			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,160,485	11,696,154	0.355714			54.00	
54.01	05402	NUCLEAR MEDICINE	573,582	8,518,217	0.067336			54.01	
57.00	05700	CT SCAN	1,033,044	17,643,741	0.058550			57.00	
60.00	06000	LABORATORY	5,530,058	43,279,773	0.127775			60.00	
60.01	06001	BLOOD LABORATORY	0	0	0.000000			60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	277,000	423,806	0.653601			63.00	
65.00	06500	RESPIRATORY THERAPY	880,544	3,119,833	0.282241			65.00	
66.00	06600	PHYSICAL THERAPY	2,553,226	9,960,193	0.256343			66.00	
67.00	06700	OCCUPATIONAL THERAPY	216,004	941,564	0.229410			67.00	
68.00	06800	SPEECH PATHOLOGY	118,357	378,137	0.313000			68.00	
69.00	06900	ELECTROCARDIOLOGY	456,276	6,393,474	0.071366			69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	238,699	1,030,296	0.231680			70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	790,923	11,807,078	0.066987			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,678,094	4,251,063	0.629982			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,597,283	7,553,267	0.476255			73.00	
76.00	03020	SONOGRAPHY	861,992	8,123,221	0.106115			76.00	
76.01	03040	AUDIOLOGY	228,892	371,377	0.616333			76.01	
76.02	03160	CARDIAC REHAB	353,883	1,204,303	0.293849			76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000			88.00	
90.00	09000	CLINIC	18,908,367	6,513,862	2.902789			90.00	
91.00	09100	EMERGENCY	3,381,857	10,833,602	0.312164			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,883,912	5,104,440	0.564981			92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000			93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	846,753	729,906	1.160085			95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	1,526,098	1,953,711	0.781128			116.00	
200.00		Subtotal (sum of lines 50 thru 199)	63,889,000	205,533,095				200.00	
201.00		Less Observation Beds	2,883,912	0				201.00	
202.00		Total (line 200 minus line 201)	61,005,088	205,533,095				202.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part I Date/Time Prepared: 4/28/2021 3:00 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	782,787	0	782,787	7,142	109.60
31.00	INTENSIVE CARE UNIT	183,367		183,367	697	263.08
43.00	NURSERY	52,276		52,276	467	111.94
200.00	Total (lines 30 through 199)	1,018,430		1,018,430	8,306	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	2,726	298,770			
31.00	INTENSIVE CARE UNIT	360	94,709			
43.00	NURSERY	0	0			
200.00	Total (lines 30 through 199)	3,086	393,479			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 4/28/2021 3:00 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	1,274,114	35,771,964	0.035618	4,445,964	158,356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,792	1,078,255	0.050815	309	16	52.00
53.00	05300	ANESTHESIOLOGY	73,964	6,851,858	0.010795	1,153,188	12,449	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786,195	11,696,154	0.067218	1,364,209	91,699	54.00
54.01	05402	NUCLEAR MEDICINE	140,807	8,518,217	0.016530	96,697	1,598	54.01
57.00	05700	CT SCAN	245,141	17,643,741	0.013894	1,561,883	21,701	57.00
60.00	06000	LABORATORY	241,311	43,279,773	0.005576	4,905,842	27,355	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,927	423,806	0.023423	160,828	3,767	63.00
65.00	06500	RESPIRATORY THERAPY	67,890	3,119,833	0.021761	605,953	13,186	65.00
66.00	06600	PHYSICAL THERAPY	203,486	9,960,193	0.020430	571,527	11,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,385	941,564	0.007843	77,986	612	67.00
68.00	06800	SPEECH PATHOLOGY	5,300	378,137	0.014016	29,837	418	68.00
69.00	06900	ELECTROCARDIOLOGY	23,161	6,393,474	0.003623	1,763,265	6,388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,535	1,030,296	0.021872	1,645	36	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,594	11,807,078	0.013347	5,787,015	77,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,694	4,251,063	0.015924	1,544,427	24,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,959	7,553,267	0.021310	1,697,875	36,182	73.00
76.00	03020	SONOGRAPHY	34,975	8,123,221	0.004306	692,677	2,983	76.00
76.01	03040	AUDIOLOGY	5,885	371,377	0.015846	0	0	76.01
76.02	03160	CARDIAC REHAB	32,363	1,204,303	0.026873	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	1,040,979	6,513,862	0.159810	80,825	12,917	90.00
91.00	09100	EMERGENCY	323,901	10,833,602	0.029898	1,219,247	36,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	280,256	5,104,440	0.054904	148,603	8,159	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,260,614	202,849,478		27,909,802	547,783	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/28/2021 3:00 pm	
						Title XVIII		Hospital		PPS	
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
						1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description						Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
						4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	7,142	0.00	2,726	30.00		
31.00	03100	INTENSIVE CARE UNIT			0	697	0.00	360	31.00		
43.00	04300	NURSERY			0	467	0.00	0	43.00		
200.00		Total (lines 30 through 199)			0	8,306		3,086	200.00		
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
						9.00					
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	30.00						
31.00	03100	INTENSIVE CARE UNIT		0	31.00						
43.00	04300	NURSERY		0	43.00						
200.00		Total (lines 30 through 199)		0	200.00						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 3:00 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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 3:00 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	0	0	0	35,771,964	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,078,255	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,851,858	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	11,696,154	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	8,518,217	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	17,643,741	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	0	43,279,773	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	423,806	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	3,119,833	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	9,960,193	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	941,564	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	378,137	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	6,393,474	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1,030,296	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11,807,078	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,251,063	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,553,267	0.000000	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	8,123,221	0.000000	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	371,377	0.000000	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	1,204,303	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	6,513,862	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	10,833,602	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	5,104,440	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0	0	0	0	202,849,478		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 3:00 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		0.000000	4,445,964	0	8,260,282	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	309	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	1,153,188	0	1,549,649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	1,364,209	0	6,090,171	0	54.00
54.01	05402	NUCLEAR MEDICINE		0.000000	96,697	0	1,416,347	0	54.01
57.00	05700	CT SCAN		0.000000	1,561,883	0	5,428,455	0	57.00
60.00	06000	LABORATORY		0.000000	4,905,842	0	4,817,897	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	160,828	0	77,380	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	605,953	0	467,123	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	571,527	0	15,493	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	77,986	0	662	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	29,837	0	1,943	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	1,763,265	0	1,585,397	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,645	0	133,916	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	5,787,015	0	2,364,571	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	1,544,427	0	178,735	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,697,875	0	3,348,642	0	73.00
76.00	03020	SONOGRAPHY		0.000000	692,677	0	1,738,243	0	76.00
76.01	03040	AUDIOLOGY		0.000000	0	0	58,591	0	76.01
76.02	03160	CARDIAC REHAB		0.000000	0	0	156,006	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
90.00	09000	CLINIC		0.000000	80,825	0	1,394,484	0	90.00
91.00	09100	EMERGENCY		0.000000	1,219,247	0	2,668,796	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	148,603	0	929,364	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			27,909,802	0	42,682,147	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 4/28/2021 3:00 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		0.295158	8,260,282	0	0	2,438,088	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.755748	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.061353	1,549,649	0	0	95,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.355714	6,090,171	0	0	2,166,359	54.00
54.01	05402	NUCLEAR MEDICINE		0.067336	1,416,347	0	0	95,371	54.01
57.00	05700	CT SCAN		0.058550	5,428,455	0	0	317,836	57.00
60.00	06000	LABORATORY		0.127775	4,817,897	0	0	615,607	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.653601	77,380	0	0	50,576	63.00
65.00	06500	RESPIRATORY THERAPY		0.282241	467,123	0	0	131,841	65.00
66.00	06600	PHYSICAL THERAPY		0.256343	15,493	0	0	3,972	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.229410	662	0	0	152	67.00
68.00	06800	SPEECH PATHOLOGY		0.313000	1,943	0	0	608	68.00
69.00	06900	ELECTROCARDIOLOGY		0.071366	1,585,397	0	0	113,143	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.231680	133,916	0	0	31,026	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.066987	2,364,571	0	0	158,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.629982	178,735	0	0	112,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.476255	3,348,642	1,377	92,276	1,594,807	73.00
76.00	03020	SONOGRAPHY		0.106115	1,738,243	0	0	184,454	76.00
76.01	03040	AUDIOLOGY		0.616333	58,591	0	0	36,112	76.01
76.02	03160	CARDIAC REHAB		0.293849	156,006	0	0	45,842	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC				0	0		88.00
90.00	09000	CLINIC		2.902789	1,394,484	0	0	4,047,893	90.00
91.00	09100	EMERGENCY		0.312164	2,668,796	0	0	833,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.564981	929,364	0	0	525,073	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		1.160085		0			95.00
200.00		Subtotal (see instructions)			42,682,147	1,377	92,276	13,597,934	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			42,682,147	1,377	92,276	13,597,934	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/28/2021 3:00 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
54.01	05402	NUCLEAR MEDICINE	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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	656	43,947		73.00
76.00	03020	SONOGRAPHY	0	0		76.00
76.01	03040	AUDIOLOGY	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	656	43,947		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	656	43,947		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					Provider CCN: 14-0143 Component CCN: 14-U143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 4/28/2021 3:00 pm	
					Title XVIII		Swing Beds - SNF		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	0.295158	0	0	0	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.755748	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.061353	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.355714	0	0	0	0	0	54.00	
54.01	05402	NUCLEAR MEDICINE	0.067336	0	0	0	0	0	54.01	
57.00	05700	CT SCAN	0.058550	0	0	0	0	0	57.00	
60.00	06000	LABORATORY	0.127775	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653601	0	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0.282241	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.256343	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.229410	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.313000	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.071366	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.231680	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.066987	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629982	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476255	0	0	0	0	0	73.00	
76.00	03020	SONOGRAPHY	0.106115	0	0	0	0	0	76.00	
76.01	03040	AUDIOLOGY	0.616333	0	0	0	0	0	76.01	
76.02	03160	CARDIAC REHAB	0.293849	0	0	0	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00	
90.00	09000	CLINIC	2.902789	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.312164	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564981	0	0	0	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	1.160085		0				95.00	
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0143

Period:

Worksheet D

Component CCN: 14-U143

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/28/2021 3:00 pm

			Title XVIII		Swing Beds - SNF		PPS	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0				50.00
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
54.01	05402	NUCLEAR MEDICINE	0	0				54.01
57.00	05700	CT SCAN	0	0				57.00
60.00	06000	LABORATORY	0	0				60.00
60.01	06001	BLOOD LABORATORY	0	0				60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
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	0				73.00
76.00	03020	SONOGRAPHY	0	0				76.00
76.01	03040	AUDIOLOGY	0	0				76.01
76.02	03160	CARDIAC REHAB	0	0				76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0	0				90.00
91.00	09100	EMERGENCY	0	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0				93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0					95.00
200.00		Subtotal (see instructions)	0	0				200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00		Net Charges (line 200 - line 201)	0	0				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/28/2021 3:00 pm

			Title XIX		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	782,787	0	782,787	7,142	109.60	30.00
31.00	INTENSIVE CARE UNIT	183,367		183,367	697	263.08	31.00
43.00	NURSERY	52,276		52,276	467	111.94	43.00
200.00	Total (lines 30 through 199)	1,018,430		1,018,430	8,306		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	402	44,059				30.00
31.00	INTENSIVE CARE UNIT	55	14,469				31.00
43.00	NURSERY	118	13,209				43.00
200.00	Total (lines 30 through 199)	575	71,737				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	1,274,114	35,771,964	0.035618	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54,792	1,078,255	0.050815	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	73,964	6,851,858	0.010795	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	786,195	11,696,154	0.067218	0	0	0	54.00
54.01	05402 NUCLEAR MEDICINE	140,807	8,518,217	0.016530	0	0	0	54.01
57.00	05700 CT SCAN	245,141	17,643,741	0.013894	0	0	0	57.00
60.00	06000 LABORATORY	241,311	43,279,773	0.005576	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	9,927	423,806	0.023423	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	67,890	3,119,833	0.021761	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	203,486	9,960,193	0.020430	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,385	941,564	0.007843	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	5,300	378,137	0.014016	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	23,161	6,393,474	0.003623	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	22,535	1,030,296	0.021872	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157,594	11,807,078	0.013347	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	67,694	4,251,063	0.015924	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	160,959	7,553,267	0.021310	0	0	0	73.00
76.00	03020 SONOGRAPHY	34,975	8,123,221	0.004306	0	0	0	76.00
76.01	03040 AUDIOLOGY	5,885	371,377	0.015846	0	0	0	76.01
76.02	03160 CARDIAC REHAB	32,363	1,204,303	0.026873	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	0	88.00
90.00	09000 CLINIC	1,040,979	6,513,862	0.159810	0	0	0	90.00
91.00	09100 EMERGENCY	323,901	10,833,602	0.029898	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	280,256	5,104,440	0.054904	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES							95.00
200.00	Total (lines 50 through 199)	5,260,614	202,849,478		0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/28/2021 3:00 pm	
						Title XIX		Hospital		PPS	
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
						1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description						Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
						4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	7,142	0.00	402	30.00		
31.00	03100	INTENSIVE CARE UNIT			0	697	0.00	55	31.00		
43.00	04300	NURSERY			0	467	0.00	118	43.00		
200.00		Total (lines 30 through 199)			0	8,306		575	200.00		
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
						9.00					
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	30.00						
31.00	03100	INTENSIVE CARE UNIT		0	31.00						
43.00	04300	NURSERY		0	43.00						
200.00		Total (lines 30 through 199)		0	200.00						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 3:00 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 3:00 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	35,771,964	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,078,255	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	6,851,858	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	11,696,154	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE		0	0	0	8,518,217	0.000000	54.01
57.00	05700	CT SCAN		0	0	0	17,643,741	0.000000	57.00
60.00	06000	LABORATORY		0	0	0	43,279,773	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	423,806	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	3,119,833	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	9,960,193	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	941,564	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	378,137	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	6,393,474	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,030,296	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	11,807,078	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	4,251,063	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	7,553,267	0.000000	73.00
76.00	03020	SONOGRAPHY		0	0	0	8,123,221	0.000000	76.00
76.01	03040	AUDIOLOGY		0	0	0	371,377	0.000000	76.01
76.02	03160	CARDIAC REHAB		0	0	0	1,204,303	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
90.00	09000	CLINIC		0	0	0	6,513,862	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	10,833,602	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	5,104,440	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	202,849,478		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 3:00 pm	
Cost Center Description				Title XIX		Hospital		PPS	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE		0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
76.00	03020	SONOGRAPHY		0.000000	0	0	0	0	76.00
76.01	03040	AUDIOLOGY		0.000000	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB		0.000000	0	0	0	0	76.02
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
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 3:00 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
PART I - ALL PROVIDER COMPONENTS				1.00	
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,142	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,142	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)			4,585	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)			2,726	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			231.33	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			237.99	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)			8,055,132	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)			8,055,132	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)			8,055,132	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)			1,127.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,074,519	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)			3,074,519	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	1,730,388	697	2,482.62	360	893,743		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)					6,185,790		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,154,052		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)					393,479		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					547,783		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					941,262		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,212,790		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)					2,557		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,127.85		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,883,912		89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/28/2021 3:00 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	782,787	8,055,132	0.097179	2,883,912	280,256		90.00	
91.00	Nursing School cost	0	8,055,132	0.000000	2,883,912	0		91.00	
92.00	Allied health cost	0	8,055,132	0.000000	2,883,912	0		92.00	
93.00	All other Medical Education	0	8,055,132	0.000000	2,883,912	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,142	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,142	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)		4,585	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)		402	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)		467	15.00
16.00	Nursery days (title V or XIX only)		118	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		231.33	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		237.99	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)		8,055,132	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)		8,055,132	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)		8,055,132	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)		1,127.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		453,396	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)		453,396	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	244,128	467	522.76	118	61,686		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,730,388	697	2,482.62	55	136,544		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)					0		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					651,626		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)					71,737		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					71,737		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					579,889		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)					2,557		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,127.85		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,883,912		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	782,787	8,055,132	0.097179	2,883,912	280,256	90.00
91.00	Nursing School cost	0	8,055,132	0.000000	2,883,912	0	91.00
92.00	Allied health cost	0	8,055,132	0.000000	2,883,912	0	92.00
93.00	All other Medical Education	0	8,055,132	0.000000	2,883,912	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 3:00 pm	
			Title XVIII	Hospital	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		4,386,340		30.00
31.00	03100	INTENSIVE CARE UNIT		1,031,350		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.295158	4,445,964	1,312,262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.755748	309	234	52.00
53.00	05300	ANESTHESIOLOGY	0.125916	1,153,188	145,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.355714	1,364,209	485,268	54.00
54.01	05402	NUCLEAR MEDICINE	0.067336	96,697	6,511	54.01
57.00	05700	CT SCAN	0.058550	1,561,883	91,448	57.00
60.00	06000	LABORATORY	0.127775	4,905,842	626,844	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653601	160,828	105,117	63.00
65.00	06500	RESPIRATORY THERAPY	0.282241	605,953	171,025	65.00
66.00	06600	PHYSICAL THERAPY	0.256343	571,527	146,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229410	77,986	17,891	67.00
68.00	06800	SPEECH PATHOLOGY	0.313000	29,837	9,339	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071366	1,763,265	125,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.231680	1,645	381	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.066987	5,787,015	387,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629982	1,544,427	972,961	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476255	1,697,875	808,621	73.00
76.00	03020	SONOGRAPHY	0.106115	692,677	73,503	76.00
76.01	03040	AUDIOLOGY	0.616333	0	0	76.01
76.02	03160	CARDIAC REHAB	0.293849	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.902789	80,825	234,618	90.00
91.00	09100	EMERGENCY	0.312164	1,219,247	380,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564981	148,603	83,958	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		27,909,802	6,185,790	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)		27,909,802		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3
			Component CCN: 14-U143		Date/Time Prepared: 4/28/2021 3:00 pm
			Title XVIII	Swing Beds - SNF	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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.295158	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.755748	0	52.00
53.00	05300	ANESTHESIOLOGY	0.125916	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.355714	0	54.00
54.01	05402	NUCLEAR MEDICINE	0.067336	0	54.01
57.00	05700	CT SCAN	0.058550	0	57.00
60.00	06000	LABORATORY	0.127775	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653601	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.282241	0	65.00
66.00	06600	PHYSICAL THERAPY	0.256343	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229410	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.313000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071366	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.231680	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.066987	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629982	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.476255	0	73.00
76.00	03020	SONOGRAPHY	0.106115	0	76.00
76.01	03040	AUDIOLOGY	0.616333	0	76.01
76.02	03160	CARDIAC REHAB	0.293849	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	2.902789	0	90.00
91.00	09100	EMERGENCY	0.312164	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564981	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/28/2021 3:00 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)	6,035,061		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)	116,662		2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		37.01	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)		11.75	31.00
32.00	Sum of lines 30 and 31		13.19	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/28/2021 3:00 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	0.000034890		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding 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)	6,151,723			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	7,265,805			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			6,987,285	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			485,983	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			7,473,268	59.00
60.00	Primary payer payments			92	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			7,473,176	61.00
62.00	Deductibles billed to program beneficiaries			828,124	62.00
63.00	Coinsurance billed to program beneficiaries			1,056	63.00
64.00	Allowable bad debts (see instructions)			120,707	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			78,460	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			99,098	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6,722,456	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			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)			1,554	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-18,884	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			11,224	70.93
70.94	HRR adjustment amount (see instructions)			-136,392	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A
Date/Time Prepared:
4/28/2021 3:00 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)			73,308	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			6,506,650	71.00
71.01	Sequestration adjustment (see instructions)			75,477	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			8,451,190	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)			-2,020,017	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			0	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)			835,562	100.00
HVB Adjustment for HSP Bonus Payment					
101.00	HVB adjustment factor (see instructions)			1.0018598040	101.00
102.00	HVB adjustment amount for HSP bonus payment (see instructions)			1,554	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)			0.9774	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			-18,884	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/28/2021 3:00 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,035,061	0	0	6,035,061	6,035,061
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	116,662	0	0	116,662	116,662
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	0
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,151,723	0	0	6,151,723	6,151,723
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,265,805	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,987,285	0	0	6,987,285	6,987,285
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	485,983	0	0	485,983	485,983
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/28/2021 3:00 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	7,473,268	7,473,268
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	473,147	0	0	473,147	473,147
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	12,836	0	0	12,836	12,836
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	485,983	0	0	485,983	485,983
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/28/2021 3:00 pm	
			Title XVIII		Hospital		PPS	
			Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
			0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01		0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02		6,035,061		6,035,061	6,035,061	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03		0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04		0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02		0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03		0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04		116,662		116,662	116,662	2.03
3.00	Operating outlier reconciliation	2.01		0	0	0	0	3.00
4.00	Managed care simulated payments	3.00		0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00		0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00		0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01		0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00		0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00		0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01		0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00		0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01		0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00		0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00		0	0	0	0	11.00
11.01	Uncompensated care payments	36.00		0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00		0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00		6,151,723	0	6,151,723	6,151,723	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00		7,265,805	0	7,265,805	7,265,805	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00		6,987,285	0	6,987,285	6,987,285	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00		485,983	0	485,983	485,983	16.00
17.00	Special add-on payments for new technologies	54.00		0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00		0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00		0	0	0	0	18.00
19.00	SUBTOTAL				0	7,473,268	7,473,268	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/28/2021 3:00 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	473,147	0	473,147	473,147	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	12,836	0	12,836	12,836	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	485,983	0	485,983	485,983	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	11,224	0	11,224	11,224	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	1,554	0	1,554	1,554	30.01
31.00	HRR adjustment (see instructions)	70.94	-136,392	0	-136,392	-136,392	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-18,884	0	-18,884	-18,884	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	73,308	73,308	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/28/2021 3:00 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		44,603	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		13,597,934	2.00
3.00	OPPS payments		8,175,256	3.00
4.00	Outlier payment (see instructions)		221,694	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.799	5.00
6.00	Line 2 times line 5		10,864,749	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		77.29	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)		44,603	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		93,653	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)		93,653	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 charge basis 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)		93,653	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		49,050	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)		44,603	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)		8,396,950	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)		1,745,453	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)		6,696,100	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)		6,696,100	30.00
31.00	Primary payer payments		1,159	31.00
32.00	Subtotal (line 30 minus line 31)		6,694,941	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)		242,493	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		157,620	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		175,171	36.00
37.00	Subtotal (see instructions)		6,852,561	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)		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)		6,852,561	40.00
40.01	Sequestration adjustment (see instructions)		79,490	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		6,773,118	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)		-47	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet E-1 Part I Date/Time Prepared: 4/28/2021 3:00 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		8,174,303		6,773,118	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	05/18/2020	276,887		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)		276,887		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)		8,451,190		6,773,118	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		2,020,017		47	6.02	
7.00	Total Medicare program liability (see instructions)		6,431,173		6,773,071	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: 14-0143

Period:

Worksheet E-1

Component CCN: 14-U143

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 3:00 pm

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		0		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/28/2021 3:00 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2	
		Component CCN: 14-U143		Date/Time Prepared: 4/28/2021 3:00 pm	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		0	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 14-0143		Period: From 10/01/2019 To 09/30/2020		Worksheet G Date/Time Prepared: 4/28/2021 3:00 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	4,222,570	0	0	0	1.00	
2.00	Temporary investments	0	0	0	0	2.00	
3.00	Notes receivable	0	0	0	0	3.00	
4.00	Accounts receivable	16,944,688	0	0	0	4.00	
5.00	Other receivable	1,052,011	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	-6,141,000	0	0	0	6.00	
7.00	Inventory	2,101,917	0	0	0	7.00	
8.00	Prepaid expenses	1,016,089	0	0	0	8.00	
9.00	Other current assets	1,799,329	0	0	0	9.00	
10.00	Due from other funds	0	0	0	0	10.00	
11.00	Total current assets (sum of lines 1-10)	20,995,604	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	2,841,557	0	0	0	12.00	
13.00	Land improvements	3,242,104	0	0	0	13.00	
14.00	Accumulated depreciation	-2,566,496	0	0	0	14.00	
15.00	Buildings	75,469,816	0	0	0	15.00	
16.00	Accumulated depreciation	-44,890,113	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	33,375,374	0	0	0	23.00	
24.00	Accumulated depreciation	-27,779,097	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	81,341	0	0	0	29.00	
30.00	Total fixed assets (sum of lines 12-29)	39,774,486	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	43,314,228	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	1,518,280	0	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	44,832,508	0	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	105,602,598	0	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	11,058,549	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	2,642,329	0	0	0	38.00	
39.00	Payroll taxes payable	563,826	0	0	0	39.00	
40.00	Notes and loans payable (short term)	3,682,947	0	0	0	40.00	
41.00	Deferred income	0	0	0	0	41.00	
42.00	Accelerated payments	0	0	0	0	42.00	
43.00	Due to other funds	0	0	0	0	43.00	
44.00	Other current liabilities	216,123	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	18,163,774	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	20,879,858	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	9,281,391	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	30,161,249	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	48,325,023	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	57,277,575				52.00	
53.00	Specific purpose fund		0			53.00	
54.00	Donor created - endowment fund balance - restricted			0		54.00	
55.00	Donor created - endowment fund balance - unrestricted			0		55.00	
56.00	Governing body created - endowment fund balance			0		56.00	
57.00	Plant fund balance - invested in plant				0	57.00	
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00	
59.00	Total fund balances (sum of lines 52 thru 58)	57,277,575	0	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	105,602,598	0	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0143

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

Worksheet G-1

Date/Time Prepared:
4/28/2021 3:00 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		57,194,893		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		544,658				2.00
3.00	Total (sum of line 1 and line 2)		57,739,551		0		3.00
4.00	CONTRIBUTIONS	14,894		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	29,589		0		0	5.00
6.00	DISTRIBUTIONS	15,420		0		0	6.00
7.00	UNRESTRICTED CONTRIBUTIONS	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)		59,903		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,799,454		0		11.00
12.00	EQUITY TRANSFER	500,456		0		0	12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION	21,423		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		521,879		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		57,277,575		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	CONTRIBUTIONS		0				4.00
5.00	RESTRICTED CONTRIBUTIONS		0				5.00
6.00	DISTRIBUTIONS		0				6.00
7.00	UNRESTRICTED CONTRIBUTIONS		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	EQUITY TRANSFER		0				12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,983,326		9,983,326	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,983,326		9,983,326	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,037,892		4,037,892	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)	4,037,892		4,037,892	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,021,218		14,021,218	17.00
18.00	Ancillary services	45,797,076	151,910,631	197,707,707	18.00
19.00	Outpatient services	0	27,245,370	27,245,370	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	732,895	732,895	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,957,327	1,957,327	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	59,818,294	181,846,223	241,664,517	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,841,423		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)		87,841,423		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet G-3 Date/Time Prepared: 4/28/2021 3:00 pm
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			241,664,517 1.00
2.00	Less contractual allowances and discounts on patients' accounts			164,490,636 2.00
3.00	Net patient revenues (line 1 minus line 2)			77,173,881 3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			87,841,423 4.00
5.00	Net income from service to patients (line 3 minus line 4)			-10,667,542 5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0 6.00
7.00	Income from investments			0 7.00
8.00	Revenues from telephone and other miscellaneous communication services			0 8.00
9.00	Revenue from television and radio service			0 9.00
10.00	Purchase discounts			0 10.00
11.00	Rebates and refunds of expenses			0 11.00
12.00	Parking lot receipts			0 12.00
13.00	Revenue from laundry and linen service			0 13.00
14.00	Revenue from meals sold to employees and guests			219,159 14.00
15.00	Revenue from rental of living quarters			60,556 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			193,662 17.00
18.00	Revenue from sale of medical records and abstracts			1,021 18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0 19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0 20.00
21.00	Rental of vending machines			0 21.00
22.00	Rental of hospital space			138,370 22.00
23.00	Governmental appropriations			0 23.00
24.00	LOSS ON DISPOSAL OF EQUIPMENT			2,850 24.00
24.01	OTHER (SPECIFY)			0 24.01
24.02	NET RENTAL INCOME			27,072 24.02
24.03	OTHER REVENUE			91,183 24.03
24.04	PARATRANSIT			227,009 24.04
24.05	OUTSIDE REHABILITATION SERVICES			2,030 24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS			71,972 24.06
24.07	INVESTMENT INCOME			3,441,219 24.07
24.50	COVID-19 PHE Funding			6,773,032 24.50
25.00	Total other income (sum of lines 6-24)			11,249,135 25.00
26.00	Total (line 5 plus line 25)			581,593 26.00
27.00	NET RENTAL LOSS			0 27.00
27.01	OTHER			0 27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES			36,935 27.02
27.03	MISCELLANEOUS			0 27.03
27.04	OTHER EXPENSES (SPECIFY)			0 27.04
27.05	OTHER EXPENSES (SPECIFY)			0 27.05
28.00	Total other expenses (sum of line 27 and subscripts)			36,935 28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			544,658 29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 3:00 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	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	33,258	33,258	0	33,258	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	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	11,906	11,906	0	11,906	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	21,131	21,131	0	21,131	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	8,522	8,522	0	8,522	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	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	0	25.00
26.00	PHYSICIAN SERVICES**	0	60,000	60,000	0	60,000	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	409,724	0	409,724	0	409,724	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**	56,945	0	56,945	0	56,945	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	16,556	0	16,556	0	16,556	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	474,839	474,839	0	474,839	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	483,225	609,656	1,092,881	0	1,092,881	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

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 3:00 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		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	33,258	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	11,906	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	21,131	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	8,522	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	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	25.00
26.00	PHYSICIAN SERVICES**	0	60,000	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	409,724	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	56,945	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	16,556	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	474,839	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	1,092,881	100.00

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

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

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

Provider CCN: 14-0143

Period:

Worksheet 0-1

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 3:00 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	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 *	0	0	0	0	0	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	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 *	0	0	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE Provider CCN: 14-0143

Period:

Worksheet 0-2

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 3:00 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	58,104	58,104	0	58,104	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	396,776	0	396,776	0	396,776	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	55,145	0	55,145	0	55,145	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	16,033	0	16,033	0	16,033	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	459,833	459,833	0	459,833	46.00
100.00	TOTAL *	467,954	517,937	985,891	0	985,891	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	58,104	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	396,776	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	55,145	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	16,033	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	459,833	46.00
100.00	TOTAL *	0	985,891	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet 0-3
		Hospice CCN: 14-1595		Date/Time Prepared: 4/28/2021 3:00 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		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	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	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 *	0	0	0	0	0	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	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 *	0	0	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet 0-4
	Hospice CCN: 14-1595	Date/Time Prepared: 4/28/2021 3:00 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		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	1,896	1,896	0	1,896	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	12,948	0	12,948	0	12,948	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	1,800	0	1,800	0	1,800	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	523	0	523	0	523	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	15,006	15,006	0	15,006	46.00
100.00	TOTAL *	15,271	16,902	32,173	0	32,173	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	1,896	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	12,948	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	1,800	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	523	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	15,006	46.00
100.00	TOTAL *	0	32,173	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: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet 0-5	
		Hospice CCN: 14-1595		Date/Time Prepared: 4/28/2021 3:00 pm	
		Hospice I			
Descriptions		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	9,954	9,954	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	95,529	95,529	3.00
4.00	ADMINISTRATIVE & GENERAL	33,258	286,078	319,336	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	16,970	16,970	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	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	11,906	0	11,906	10.00
11.00	MEDICAL RECORDS	0	24,686	24,686	11.00
12.00	STAFF TRANSPORTATION	21,131	0	21,131	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	8,522	0	8,522	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	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	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	985,891	0	985,891	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	32,173	0	32,173	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	1,092,881	433,217	1,526,098	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 3:00 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	9,954	9,954				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	95,529	0	0	95,529		3.00
4.00	ADMINISTRATIVE & GENERAL	319,336	9,954	0	0	329,290	4.00
5.00	PLANT OPERATION & MAINTENANCE	16,970	0	0	0	16,970	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	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	11,906	0	0	0	11,906	10.00
11.00	MEDICAL RECORDS	24,686	0	0	0	24,686	11.00
12.00	STAFF TRANSPORTATION	21,131	0	0	0	21,131	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	8,522	0	0	0	8,522	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	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	985,891			92,510	1,078,401	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	32,173	0	0	3,019	35,192	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	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	1,526,098	9,954	0	95,529	1,526,098	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 3:00 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	329,290						4.00
5.00	PLANT OPERATION & MAINTENANCE	4,669	21,639					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	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,276	0			0		10.00
11.00	MEDICAL RECORDS	6,792	0			0		11.00
12.00	STAFF TRANSPORTATION	5,814	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	2,345	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	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	296,711						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	9,683	21,639		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0		99.00
100.00	TOTAL	329,290	21,639		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	15,182				10.00
11.00	MEDICAL RECORDS	0		31,478			11.00
12.00	STAFF TRANSPORTATION	0			26,945		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	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	14,702	30,483	26,945	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	480	995	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	15,182	31,478	26,945	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 3:00 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	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	10,867					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0			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	10,690	0	0		1,457,932	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	177	0	0	0	68,166	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	10,867	0	0	0	1,526,098	100.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 3:00 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	974					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	483,225			3.00
4.00	ADMINISTRATIVE & GENERAL	974	0	0	-329,290	1,196,808	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	16,970	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	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	11,906	10.00
11.00	MEDICAL RECORDS	0	0	0	0	24,686	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	21,131	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	8,522	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	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			467,954	0	1,078,401	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	15,271	0	35,192	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0	0	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)	9,954	0	95,529		329,290	100.00
101.00	UNIT COST MULTIPLIER	10.219713	0.000000	0.197691		0.275140	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 3:00 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	974					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		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	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		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					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	974	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	21,639	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	22.216632	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Descriptions		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	Hospice I 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	3,101					10.00
11.00	MEDICAL RECORDS		3,101				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	7,863	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			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	3,003	3,003	100	0	7,735	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	98	98	0	0	128	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	15,182	31,478	26,945	0	10,867	100.00
101.00	UNIT COST MULTIPLIER	4.895840	10.150919	269.450000	0.000000	1.382042	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 3:00 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (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 (DELETED)		0			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	0			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		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	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-7

Hospice CCN: 14-1595

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

Date/Time Prepared:
4/28/2021 3:00 pm

			Hospice I		
Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)		
			HCHC	HRHC	HIRC
	0	1.00	2.00	3.00	4.00
ANCILLARY SERVICE COST CENTERS					
1.00 PHYSICAL THERAPY	66.00	0.256343	0	0	0
2.00 OCCUPATIONAL THERAPY	67.00	0.229410	0	0	0
3.00 SPEECH PATHOLOGY	68.00	0.313000	0	0	0
4.00 DRUGS CHARGED TO PATIENTS	73.00	0.476255	0	0	0
5.00 DURABLE MEDICAL EQUIP-RENTED	96.00				
6.00 LABORATORY	60.00	0.127775	0	0	0
6.01 BLOOD LABORATORY	60.01	0.000000	0	0	0
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.066987	0	0	0
8.00 OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	0
9.00 RADIOLOGY-THERAPEUTIC	55.00				
10.00 SONOGRAPHY	76.00	0.106115	0	0	0
10.01 AUDIOLOGY	76.01	0.616333	0	0	0
10.02 CARDIAC REHAB	76.02	0.293849	0	0	0
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)
	5.00		6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS					
1.00 PHYSICAL THERAPY	0	0	0	0	0
2.00 OCCUPATIONAL THERAPY	0	0	0	0	0
3.00 SPEECH PATHOLOGY	0	0	0	0	0
4.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
5.00 DURABLE MEDICAL EQUIP-RENTED					
6.00 LABORATORY	0	0	0	0	0
6.01 BLOOD LABORATORY	0	0	0	0	0
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
8.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
9.00 RADIOLOGY-THERAPEUTIC					
10.00 SONOGRAPHY	0	0	0	0	0
10.01 AUDIOLOGY	0	0	0	0	0
10.02 CARDIAC REHAB	0	0	0	0	0
11.00 Totals (sum of lines 1-11)		0	0	0	0

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0143

Period:

Worksheet 0-8

Hospice CCN: 14-1595

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 3:00 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)			1,457,932 6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,003 7.00
8.00	Total average cost per diem (line 6 divided by line 7)			485.49 8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,003	0	9.00
10.00	Program cost (line 8 times line 9)	1,457,926	0	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)			68,166 16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			98 17.00
18.00	Total average cost per diem (line 16 divided by line 17)			695.57 18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	98	0	19.00
20.00	Program cost (line 18 times line 19)	68,166	0	20.00
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,526,098 21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,101 22.00
23.00	Average cost per diem (line 21 divided by line 22)			492.13 23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0143	Period: From 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 4/28/2021 3:00 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		473,147	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,836	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)		14.81	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		485,983	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