

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/26/2021 8:50 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/26/2021	Time: 8:50 am
	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 IROQUOIS MEMORIAL HOSPITAL (14-0167) 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title XVIII		HIT	Title XIX	
		Title V	Part A	Part B		
		1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-36,391	-16,983	0	0 1.00
2.00	Subprovider - IPF	0	0	0		0 2.00
3.00	Subprovider - IRF	0	0	0		0 3.00
5.00	Swing Bed - SNF	0	0	0		0 5.00
6.00	Swing Bed - NF	0				0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0 7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0 9.00
10.00	RURAL HEALTH CLINIC I	0		66,349		0 10.00
10.01	RURAL HEALTH CLINIC II	0		-20,467		0 10.01
10.02	RURAL HEALTH CLINIC III	0		-43,215		0 10.02
10.03	RURAL HEALTH CLINIC IV	0		-27,548		0 10.03
200.00	Total	0	-36,391	-41,864	0	0 200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0167		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/26/2021 8:50 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 200 FAIRMAN AVENUE			PO Box:				1.00		
2.00	City: WATSEKA			State: IL		Zip Code: 60970		County:		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		IROQUOIS MEMORIAL HOSPITAL	140167	99914	1	07/01/1996	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		IROQUOIS MEMORIAL HOSPITAL	14U167	99914		12/31/2006	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		IROQUOIS RESIDENT HOME	146049	99914		08/18/2003	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		IROQUOIS HOME HEALTH	147586	99914		09/30/1994	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		IROQUOIS MEMORIAL HOSPICE	141616	99914		11/04/2004			
15.00	Hospital-Based Health Clinic - RHC		GILMAN CLINIC	143424	99914		09/04/1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		MILFORD CLINIC	143425	99914		10/09/1996	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		KENTLAND CLINIC	153979	99915		10/29/1996	N	O	N
15.03	Hospital-Based Health Clinic - RHC IV		MPS CLINIC	148551	99914		02/05/2016	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019		09/30/2020	
21.00	Type of Control (see instructions)						2			
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/26/2021 8:50 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
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.	8	0	0	0	133	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					10/01/2019	09/30/2020	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no 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		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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		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		
		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) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/26/2021 8:50 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			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	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
						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
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
						75.00
						76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/26/2021 8:50 am
		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:	585,984	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.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0167		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/26/2021 8:50 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/26/2021 8:50 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/29/2021	N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		Y 01/29/2021
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.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/26/2021 8:50 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(502) 992-3508	SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/26/2021 8:50 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/26/2021 8:50 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	35	12,810		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	366			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
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		61				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/26/2021 8:50 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	662	5	944			1.00
2.00	HMO and other (see instructions)	14	136				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)	662	5	944			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)	662	5	944	0.00	192.19	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	835	0	10,434	0.00	27.59	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,772	0	3,935	0.00	9.99	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	19	0	19	0.00	17.37	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,626	0	3,866	0.00	4.71	26.00
26.01	RURAL HEALTH CLINIC II	911	0	2,429	0.00	4.18	26.01
26.02	RURAL HEALTH CLINIC III	2,804	0	4,333	0.00	7.91	26.02
26.03	RURAL HEALTH CLINIC IV	9,263	0	14,178	0.00	7.16	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	271.10	27.00
28.00	Observation Bed Days		7	444			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/26/2021 8:50 am

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	242	2	401	1.00
2.00 HMO and other (see instructions)			5	58		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	242	2	401	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/26/2021 8:50 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	13,812,793	126,335	13,939,128	563,885.05	24.72
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		15,690	0	15,690	104.00	150.87
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		266,782	0	266,782	2,960.61	90.11
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,531,640	0	2,531,640	49,846.00	50.79
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,277,801	0	1,277,801	57,370.90	22.27
10.00	Excluded area salaries (see instructions)		1,257,082	0	1,257,082	66,059.79	19.03
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		247,998	0	247,998	4,219.25	58.78
12.00	Contract labor: Top level management and other management and administrative services		478,912	0	478,912	2,080.00	230.25
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
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)		1,660,903	0	1,660,903		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		515,546	0	515,546		
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		1,040	0	1,040		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		26,367	0	26,367		
24.00	Wage-related costs (RHC/FQHC)		310,331	0	310,331		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/26/2021 8:50 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	185,186	2,000	187,186	6,496.75	28.81	26.00
27.00	Administrative & General	5.00	1,337,439	16,547	1,353,986	72,834.92	18.59	27.00
28.00	Administrative & General under contract (see inst.)		121,323	0	121,323	1,207.27	100.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	326,540	761	327,301	19,666.18	16.64	30.00
31.00	Laundry & Linen Service	8.00	43,451	0	43,451	3,240.25	13.41	31.00
32.00	Housekeeping	9.00	289,083	23	289,106	24,602.29	11.75	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	393,860	-118,197	275,663	16,254.64	16.96	34.00
35.00	Dietary under contract (see instructions)		612	0	612	13.00	47.08	35.00
36.00	Cafeteria	11.00	0	118,197	118,197	8,187.34	14.44	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	91,074	0	91,074	2,104.03	43.29	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	251,668	2,662	254,330	11,896.78	21.38	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/26/2021 8:50 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	11,136,306	126,335	11,262,641	512,298.71	21.98	1.00
2.00	Excluded area salaries (see instructions)	2,534,883	0	2,534,883	123,430.69	20.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	8,601,423	126,335	8,727,758	388,868.02	22.44	3.00
4.00	Subtotal other wages & related costs (see inst.)	726,910	0	726,910	6,299.25	115.40	4.00
5.00	Subtotal wage-related costs (see inst.)	1,661,943	0	1,661,943	0.00	19.04	5.00
6.00	Total (sum of lines 3 thru 5)	10,990,276	126,335	11,116,611	395,167.27	28.13	6.00
7.00	Total overhead cost (see instructions)	3,040,236	21,993	3,062,229	166,503.45	18.39	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	1,569,155	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-26,580	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	966,168	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	5,444	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,514,187	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0167

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 4/26/2021 8:50 am

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	247,998	2,514,187	1.00
2.00	Hospital	247,998	2,514,187	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-7586		Period: From 10/01/2019 To 09/30/2020 Worksheet S-4 Date/Time Prepared: 4/26/2021 8:50 am		
				Home Health Agency I PPS		
				1.00		
0.00	County					
		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00
HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,621	0	70	1,691
2.00	Unduplicated Census Count (see instructions)	0.00	191.00	9.00	28.00	228.00
				Number of Employees (Full Time Equivalent)		
		Enter the number of hours in your normal work week		Staff	Contract	Total
		0		1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00
4.00	Director(s) and Assistant Director(s)			0.03	0.00	0.03
5.00	Other Administrative Personnel			0.00	0.00	0.00
6.00	Direct Nursing Service			0.32	0.00	0.32
7.00	Nursing Supervisor			0.00	0.00	0.00
8.00	Physical Therapy Service			1.47	0.00	1.47
9.00	Physical Therapy Supervisor			0.00	0.00	0.00
10.00	Occupational Therapy Service			0.50	0.00	0.50
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00
12.00	Speech Pathology Service			0.00	0.00	0.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00
14.00	Medical Social Service			0.01	0.00	0.01
15.00	Medical Social Service Supervisor			0.00	0.00	0.00
16.00	Home Health Aide			0.81	0.00	0.81
17.00	Home Health Aide Supervisor			0.00	0.00	0.00
18.00	Other (specify)			0.00	0.00	0.00
HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3		
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	16580				
20.01		19180				
20.02		99914				
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,274	199	26	14	1,513
22.00	Skilled Nursing Visit Charges	204,646	32,142	4,200	2,261	243,249
23.00	Physical Therapy Visits	723	68	9	7	807
24.00	Physical Therapy Visit Charges	116,617	10,983	1,454	1,131	130,185
25.00	Occupational Therapy Visits	178	48	3	1	230
26.00	Occupational Therapy Visit Charges	27,458	7,753	485	162	35,858
27.00	Speech Pathology Visits	11	6	0	0	17
28.00	Speech Pathology Visit Charges	1,777	969	0	0	2,746
29.00	Medical Social Service Visits	5	1	0	0	6
30.00	Medical Social Service Visit Charges	1,003	201	0	0	1,204
31.00	Home Health Aide Visits	146	52	1	0	199
32.00	Home Health Aide Visit Charges	14,638	5,214	100	0	19,952
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,337	374	39	22	2,772
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	366,139	57,262	6,239	3,554	433,194
36.00	Total Number of Episodes (standard/non outlier)	202		17	3	222
37.00	Total Number of Outlier Episodes		17		0	17
38.00	Total Non-Routine Medical Supply Charges	8,535	4,147	19	2	12,703

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-3424		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/26/2021 8:50 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	508 E CRESENT		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GILMAN IL 60938		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0		3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		08:30		18:30	
		07:00		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00		11.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	07:00	17:00	08:30
		18:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-3424

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

RHC I

Cost

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-3425		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/26/2021 8:50 am	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	207 N AXTEL		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MILFORD IL 60983		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		08:30		17:00	
		17:00		07:00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:30	18:30	08:30
		17:00		11.00	

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0167	Period: From 10/01/2019	Worksheet S-8
			Component CCN: 14-3425	To 09/30/2020	Date/Time Prepared: 4/26/2021 8:50 am
			RHC II		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	07:00	17:00		11.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 15-3979		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/26/2021 8:50 am	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	303 N SEVENTH		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KENTLAND IN		47951	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:00		17:00	08:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	NEWTON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	18:30	07:00	17:00	08:30
		18:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 15-3979

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

RHC III

Cost

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-8551		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/26/2021 8:50 am	
		RHC IV		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	200 FAIRMAN AVE		1.00	
	City	State	ZIP Code		
	1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	WATSEKA IL 60970		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0		3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from to		from to	
		1.00 2.00		3.00 4.00	
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)				
11.00	CLINIC	07:00		17:00 08:30 11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N		V	
		1.00		2.00	
		XVIII		XIX	
		3.00		4.00	
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday		Wednesday	
		to		from to	
		6.00		7.00 8.00	
		Thursday		from to	
		9.00		10.00	
Facility hours of operations (1)					
11.00	CLINIC	18:30 07:00		17:00 08:30 18:30 11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-8551

From 10/01/2019

To 09/30/2020

Date/Time Prepared:

4/26/2021 8:50 am

RHC IV

Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA			Provider CCN: 14-0167	Period: From 10/01/2019	Worksheet S-9
			Hospice CCN: 14-1616	To 09/30/2020	PARTS I THROUGH IV
			Hospice I		Date/Time Prepared: 4/26/2021 8:50 am

		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	11,362	33	905	12,300	11.00
12.00	Hospice Inpatient Respite Care	15	0	0	15	12.00
13.00	Hospice General Inpatient Care	29	0	13	42	13.00
14.00	Total Hospice Days	11,406	33	918	12,357	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10 Date/Time Prepared: 4/26/2021 8:50 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.511390 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,068,245		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	8,638,673		6.00
7.00	Medicaid cost (line 1 times line 6)	4,417,731		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,349,486		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,349,486		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	32,623	30,758	63,381 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	16,683	30,758	47,441 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	16,683	30,758	47,441 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,018,092		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	0		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	0		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,018,092		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,032,032		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,079,473		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,428,959		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0167

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

Worksheet A

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	973,389	973,389	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	704,867	704,867	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	185,186	262,475	447,661	1,561,661	4.00
5.01	00570	ADMITTING	211,313	19,691	231,004	-1,163	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	61,588	27,620	89,208	-2,182	5.02
5.03	00550	DATA PROCESSING	279,079	452,012	731,091	-5,335	5.03
5.04	01160	COMMUNICATIONS	0	278,054	278,054	31,201	5.04
5.05	00590	BUSINESS OFFICE	311,123	48,817	359,940	-1,991	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	474,336	5,848,494	6,322,830	-2,722,816	5.06
7.00	00700	OPERATION OF PLANT	326,540	686,189	1,012,729	-16,992	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,451	3,761	47,212	0	8.00
9.00	00900	HOUSEKEEPING	289,083	39,254	328,337	0	9.00
10.00	01000	DIETARY	393,860	289,248	683,108	-205,450	10.00
11.00	01100	CAFETERIA	0	0	0	204,808	11.00
13.00	01300	NURSING ADMINISTRATION	91,074	14,090	105,164	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	111,571	111,571	-32,908	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	251,668	27,917	279,585	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,195,203	252,220	1,447,423	-4,442	30.00
44.00	04400	SKILLED NURSING FACILITY	1,277,801	200,039	1,477,840	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	504,159	412,698	916,857	-42,097	50.00
53.00	05300	ANESTHESIOLOGY	0	363,942	363,942	-621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,260	678,039	1,064,299	-19,969	54.00
57.00	05700	CT SCAN	179,106	131,377	310,483	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,248	200,782	268,030	0	58.00
60.00	06000	LABORATORY	593,574	1,205,788	1,799,362	-60,266	60.00
65.00	06500	RESPIRATORY THERAPY	436,504	86,619	523,123	-43,144	65.00
66.00	06600	PHYSICAL THERAPY	659,698	45,863	705,561	-5,086	66.00
69.00	06900	ELECTROCARDIOLOGY	3,259	5,947	9,206	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	184,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	150,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	440,218	1,198,850	1,639,068	-13,407	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	483,665	115,465	599,130	79,584	88.00
88.01	08801	RURAL HEALTH CLINIC II	307,428	100,259	407,687	-146,459	88.01
88.02	08802	RURAL HEALTH CLINIC III	748,174	201,528	949,702	-42,915	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,106,011	1,105,380	2,211,391	-224,852	88.03
90.00	09000	CLINIC	219,700	171,052	390,752	-32,189	90.00
91.00	09100	EMERGENCY	1,029,402	2,374,407	3,403,809	-14,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,797	-2,576	-779	0	95.00
101.00	10100	HOME HEALTH AGENCY	479,165	91,863	571,028	-13,450	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		249,948	249,948	-234,141	113.00
116.00	11600	HOSPICE	663,213	316,667	979,880	-4,827	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,699,886	17,615,350	31,315,236	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	377	377	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	38,939	12,584	51,523	0	194.01
194.02	07952	REFERENCE LAB	73,968	-6,807	67,161	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	13,812,793	17,621,504	31,434,297	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0167

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

Worksheet A

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	973,389	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	704,867	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,641	2,005,681	4.00
5.01	00570	ADMITTING	0	229,841	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	87,026	5.02
5.03	00550	DATA PROCESSING	0	725,756	5.03
5.04	01160	COMMUNICATIONS	-3,156	306,099	5.04
5.05	00590	BUSINESS OFFICE	0	357,949	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	-1,450,079	2,149,935	5.06
7.00	00700	OPERATION OF PLANT	-11,427	984,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,212	8.00
9.00	00900	HOUSEKEEPING	0	328,337	9.00
10.00	01000	DIETARY	0	477,658	10.00
11.00	01100	CAFETERIA	-117,512	87,296	11.00
13.00	01300	NURSING ADMINISTRATION	0	105,164	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,663	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-93,539	186,046	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-244,529	1,198,452	30.00
44.00	04400	SKILLED NURSING FACILITY	0	1,477,840	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-97,214	777,546	50.00
53.00	05300	ANESTHESIOLOGY	-354,573	8,748	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-31,382	1,012,948	54.00
57.00	05700	CT SCAN	-900	309,583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	268,030	58.00
60.00	06000	LABORATORY	-174,355	1,564,741	60.00
65.00	06500	RESPIRATORY THERAPY	-75	479,904	65.00
66.00	06600	PHYSICAL THERAPY	-2,275	698,200	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,206	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	184,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	150,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-40	1,625,621	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-35	678,679	88.00
88.01	08801	RURAL HEALTH CLINIC II	-29	261,199	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	906,787	88.02
88.03	08803	RURAL HEALTH CLINIC IV	-67,437	1,919,102	88.03
90.00	09000	CLINIC	-32,404	326,159	90.00
91.00	09100	EMERGENCY	-2,154,249	1,235,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	779	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	557,578	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-15,807	0	113.00
116.00	11600	HOSPICE	-317	974,736	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,854,196	26,461,040	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	377	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	51,523	194.01
194.02	07952	REFERENCE LAB	0	67,161	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,854,196	26,580,101	200.00

RECLASSIFICATIONS

Provider CCN: 14-0167

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	184,911		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	150,613		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	335,524		
	B - DRUGS					
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	18,288		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	0		0	18,288		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	837,587		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	606,528		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	1,444,115		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	135,802		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	98,339		2.00
	0		0	234,141		
	E - TELEPHONE					
1.00	COMMUNICATIONS	5.04	0	31,201		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	31,201		
	F - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,568,910		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	1,568,910		
	G - CAFETERIA					
1.00	CAFETERIA	11.00	118,197	86,611		1.00
	0		118,197	86,611		

RECLASSIFICATIONS

Provider CCN: 14-0167

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

Worksheet A-6

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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - RHC SALARIES				
1.00	OPERATING ROOM	50.00	85,228		1.00
2.00	RURAL HEALTH CLINIC	88.00	113,494		2.00
3.00	CLINIC	90.00	28,409		3.00
			227,131	0	
	I - COVID SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,000	0	1.00
2.00	ADMITTING	5.01	3,190	0	2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	3,282	0	3.00
4.00	OTHER ADMINISTRATIVE & GENERAL	5.06	10,075	0	4.00
5.00	OPERATION OF PLANT	7.00	761	0	5.00
6.00	HOUSEKEEPING	9.00	23	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	2,662	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	3,519	0	8.00
9.00	OPERATING ROOM	50.00	23,436	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	8,099	0	10.00
11.00	CT SCAN	57.00	5,276	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,923	0	12.00
13.00	LABORATORY	60.00	46,013	0	13.00
14.00	RESPIRATORY THERAPY	65.00	715	0	14.00
15.00	PHYSICAL THERAPY	66.00	14,222	0	15.00
16.00	RURAL HEALTH CLINIC II	88.01	288	0	16.00
17.00	CLINIC	90.00	851	0	17.00
	TOTALS		126,335	0	
500.00	Grand Total: Increases		471,663	3,718,790	500.00

RECLASSIFICATIONS

Provider CCN: 14-0167

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

Worksheet A-6

Date/Time Prepared:
4/26/2021 8:50 am

		Decreases					4/26/2021 8:00 am	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
A - MEDICAL SUPPLIES								
1.00	PURCHASING RECEIVING AND STORES	5.02	0	1,865	0		1.00	
2.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,157	0		2.00	
3.00	OPERATION OF PLANT	7.00	0	81	0		3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,833	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	3,793	0		5.00	
6.00	OPERATING ROOM	50.00	0	122,074	0		6.00	
7.00	ANESTHESIOLOGY	53.00	0	621	0		7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,886	0		8.00	
9.00	LABORATORY	60.00	0	50,627	0		9.00	
10.00	RESPIRATORY THERAPY	65.00	0	43,144	0		10.00	
11.00	PHYSICAL THERAPY	66.00	0	61	0		11.00	
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,691	0		12.00	
13.00	CLINIC	90.00	0	42,922	0		13.00	
14.00	EMERGENCY	91.00	0	10,769	0		14.00	
	0		0	335,524				
B - DRUGS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,378	0		1.00	
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,932	0		2.00	
3.00	DIETARY	10.00	0	642	0		3.00	
4.00	OPERATING ROOM	50.00	0	1,104	0		4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,594	0		5.00	
6.00	LABORATORY	60.00	0	361	0		6.00	
7.00	CLINIC	90.00	0	3,163	0		7.00	
8.00	EMERGENCY	91.00	0	1,114	0		8.00	
	0		0	18,288				
C - DEPRECIATION								
1.00	DATA PROCESSING	5.03	0	210	9		1.00	
2.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,441,087	9		2.00	
3.00	OPERATION OF PLANT	7.00	0	1,752	0		3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	649	0		4.00	
5.00	OPERATING ROOM	50.00	0	417	0		5.00	
	0		0	1,444,115				
D - INTEREST								
1.00	INTEREST EXPENSE	113.00	0	234,141	11		1.00	
2.00		0.00	0	0	11		2.00	
	0		0	234,141				
E - TELEPHONE								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	317	0		1.00	
2.00	ADMITTING	5.01	0	1,163	0		2.00	
3.00	PURCHASING RECEIVING AND STORES	5.02	0	317	0		3.00	
4.00	DATA PROCESSING	5.03	0	5,125	0		4.00	
5.00	BUSINESS OFFICE	5.05	0	1,991	0		5.00	
6.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	2,331	0		6.00	
7.00	OPERATION OF PLANT	7.00	0	15,159	0		7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	75	0		8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,441	0		9.00	
10.00	LABORATORY	60.00	0	29	0		10.00	
11.00	PHYSICAL THERAPY	66.00	0	1,812	0		11.00	
12.00	EMERGENCY	91.00	0	1,441	0		12.00	
	0		0	31,201				
F - EMPLOYEE BENEFITS								
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,296,529	0		1.00	
2.00	OPERATING ROOM	50.00	0	3,730	0		2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,048	0		3.00	
4.00	LABORATORY	60.00	0	9,249	0		4.00	
5.00	PHYSICAL THERAPY	66.00	0	3,213	0		5.00	
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	338	0		6.00	
7.00	RURAL HEALTH CLINIC	88.00	0	33,910	0		7.00	
8.00	RURAL HEALTH CLINIC II	88.01	0	34,515	0		8.00	
9.00	RURAL HEALTH CLINIC III	88.02	0	41,365	0		9.00	
10.00	RURAL HEALTH CLINIC IV	88.03	0	111,215	0		10.00	
11.00	CLINIC	90.00	0	14,513	0		11.00	
12.00	EMERGENCY	91.00	0	1,008	0		12.00	
13.00	HOME HEALTH AGENCY	101.00	0	13,450	0		13.00	
14.00	HOSPICE	116.00	0	4,827	0		14.00	
	0		0	1,568,910				

RECLASSIFICATIONS

Provider CCN: 14-0167

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

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - CAFETERIA						
1.00	DIETARY	10.00	118,197	86,611	0		1.00
	0		118,197	86,611			
	H - RHC SALARIES						
1.00	RURAL HEALTH CLINIC II	88.01	111,944	0	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	1,550	0	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	113,637	0	0		3.00
	0		227,131	0			
	I - COVID SALARY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,000	0		1.00
2.00	ADMITTING	5.01	0	3,190	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	3,282	0		3.00
4.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	10,075	0		4.00
5.00	OPERATION OF PLANT	7.00	0	761	0		5.00
6.00	HOUSEKEEPING	9.00	0	23	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,662	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	3,519	0		8.00
9.00	OPERATING ROOM	50.00	0	23,436	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,099	0		10.00
11.00	CT SCAN	57.00	0	5,276	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,923	0		12.00
13.00	LABORATORY	60.00	0	46,013	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	715	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	14,222	0		15.00
16.00	RURAL HEALTH CLINIC II	88.01	0	288	0		16.00
17.00	CLINIC	90.00	0	851	0		17.00
	TOTALS		0	126,335			
500.00	Grand Total: Decreases		345,328	3,845,125			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/26/2021 8:50 am

		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	337,950	0	0	0	5,000	1.00
2.00	Land Improvements	483,553	197	0	197	0	2.00
3.00	Buildings and Fixtures	25,914,340	266,760	0	266,760	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	16,002,690	709,124	0	709,124	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,738,533	976,081	0	976,081	5,000	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,738,533	976,081	0	976,081	5,000	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	332,950	0				1.00
2.00	Land Improvements	483,750	0				2.00
3.00	Buildings and Fixtures	26,181,100	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	16,711,814	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	43,709,614	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	43,709,614	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/26/2021 8:50 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,709,614	0	43,709,614	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	43,709,614	0	43,709,614	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	837,587	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	606,528	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,444,115	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	135,802	0	0	0	973,389	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98,339	0	0	0	704,867	2.00
3.00	Total (sum of lines 1-2)	234,141	0	0	0	1,678,256	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0167

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

Worksheet A-8

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-15,807	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,156	COMMUNICATIONS	5.04	0	7.00
8.00	Television and radio service (chapter 21)	A	-11,177	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	-3,080,011			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	-360,000			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-116,554	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0167

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

Worksheet A-8

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	LOBBYING DUES	A	-8,545	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.00
33.01	LOBBYING DUES	A	-257	HOSPICE	116.00	0	33.01
34.00	MISCELLANEOUS NON-PATIENT REVENUE	B	-1,391	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	MISCELLANEOUS NON-PATIENT REVENUE	B	-91,870	OTHER ADMINISTRATIVE & GENERAL	5.06	0	34.01
34.02	MISCELLANEOUS NON-PATIENT REVENUE	B	-250	OPERATION OF PLANT	7.00	0	34.02
34.03	MISCELLANEOUS NON-PATIENT REVENUE	B	-958	CAFETERIA	11.00	0	34.03
34.04	MISCELLANEOUS NON-PATIENT REVENUE	B	-93,539	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
34.05	MISCELLANEOUS NON-PATIENT REVENUE	B	-75	RESPIRATORY THERAPY	65.00	0	34.05
34.06	MISCELLANEOUS NON-PATIENT REVENUE	B	-2,275	PHYSICAL THERAPY	66.00	0	34.06
34.07	MISCELLANEOUS NON-PATIENT REVENUE	B	-40	DRUGS CHARGED TO PATIENTS	73.00	0	34.07
34.08	MISCELLANEOUS NON-PATIENT REVENUE	B	-67,437	RURAL HEALTH CLINIC IV	88.03	0	34.08
34.09	NONALLOWABLE EXPENSES	A	-2,250	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.09
34.10	NONALLOWABLE EXPENSES	A	-96,589	OTHER ADMINISTRATIVE & GENERAL	5.06	0	34.10
34.11	NONALLOWABLE EXPENSES	A	-35	RURAL HEALTH CLINIC	88.00	0	34.11
35.00	NONALLOWABLE EXPENSES	A	-29	RURAL HEALTH CLINIC II	88.01	0	35.00
35.01	NONALLOWABLE EXPENSES	A	-60	HOSPICE	116.00	0	35.01
35.02	PROVIDER TAX	A	-902,670	OTHER ADMINISTRATIVE & GENERAL	5.06	0	35.02
35.03	AMBULANCE OFFSET	A	779	AMBULANCE SERVICES	95.00	0	35.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,854,196				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0167

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

Worksheet A-8-1

Date/Time Prepared:
4/26/2021 8:50 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	60,000	420,000	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			60,000	420,000	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

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

Provider CCN: 14-0167

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

Worksheet A-8-1

Date/Time Prepared:
4/26/2021 8:50 am

	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	-360,000	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-360,000			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0167

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

Worksheet A-8-2

Date/Time Prepared:
4/26/2021 8:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	-9,595	-9,595	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	244,529	244,529	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	97,214	97,214	0	246,400	0	3.00
4.00	53.00	ANESTHESIOLOGY	354,573	354,573	0	239,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	44,977	27,080	17,897	271,900	104	5.00
6.00	57.00	CT SCAN	900	900	0	271,900	0	6.00
7.00	60.00	LABORATORY	174,355	174,355	0	260,300	0	7.00
8.00	90.00	CLINIC	32,404	32,404	0	211,500	0	8.00
9.00	91.00	EMERGENCY	2,154,249	2,154,249	0	211,500	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,093,606	3,075,709	17,897		104	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	13,595	680	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			13,595	680	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	0	0	0	-9,595		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	244,529		2.00
3.00	50.00	OPERATING ROOM	0	0	0	97,214		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	354,573		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	13,595	4,302	31,382		5.00
6.00	57.00	CT SCAN	0	0	0	900		6.00
7.00	60.00	LABORATORY	0	0	0	174,355		7.00
8.00	90.00	CLINIC	0	0	0	32,404		8.00
9.00	91.00	EMERGENCY	0	0	0	2,154,249		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	13,595	4,302	3,080,011		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	973,389	973,389			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	704,867		704,867		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,005,681	12,302	1,637	2,019,620	4.00
5.01	00570	ADMITTING	229,841	5,827	1,388	31,502	268,558 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	87,026	6,647	931	9,527	0 5.02
5.03	00550	DATA PROCESSING	725,756	17,020	44,755	40,986	0 5.03
5.04	01160	COMMUNICATIONS	306,099	1,226	0	0	0 5.04
5.05	00590	BUSINESS OFFICE	357,949	62,328	407	45,692	0 5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	2,149,935	50,461	6,160	71,141	0 5.06
7.00	00700	OPERATION OF PLANT	984,310	102,230	85,310	48,068	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,212	15,801	88	6,381	0 8.00
9.00	00900	HOUSEKEEPING	328,337	4,608	98	42,458	0 9.00
10.00	01000	DIETARY	477,658	23,026	1,645	40,484	0 10.00
11.00	01100	CAFETERIA	87,296	7,163	0	17,359	0 11.00
13.00	01300	NURSING ADMINISTRATION	105,164	7,322	0	13,375	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,663	10,366	4,849	0	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	186,046	9,264	58	37,351	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,198,452	63,954	40,523	176,046	10,386 30.00
44.00	04400	SKILLED NURSING FACILITY	1,477,840	67,439	19,737	187,653	15,895 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	777,546	112,217	172,198	90,000	18,716 50.00
53.00	05300	ANESTHESIOLOGY	8,748	758	577	0	504 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,948	31,547	67,117	57,916	25,537 54.00
57.00	05700	CT SCAN	309,583	6,296	91,286	27,079	32,038 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	268,030	0	290	10,159	6,382 58.00
60.00	06000	LABORATORY	1,564,741	24,252	17,699	93,930	47,319 60.00
65.00	06500	RESPIRATORY THERAPY	479,904	14,134	12,845	64,210	2,373 65.00
66.00	06600	PHYSICAL THERAPY	698,200	85,155	24,590	98,973	11,972 66.00
69.00	06900	ELECTROCARDIOLOGY	9,206	5,014	5,267	479	2,142 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,911	0	0	0	4,513 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,613	0	0	0	2,506 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,625,621	24,252	4,107	64,651	22,236 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	678,679	26,987	444	87,699	3,101 88.00
88.01	08801	RURAL HEALTH CLINIC II	261,199	19,334	15,426	28,751	1,811 88.01
88.02	08802	RURAL HEALTH CLINIC III	906,787	29,336	8,044	109,650	3,903 88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,919,102	16,620	12,890	145,741	11,517 88.03
90.00	09000	CLINIC	326,159	44,813	3,032	36,563	3,238 90.00
91.00	09100	EMERGENCY	1,235,228	31,829	25,279	151,179	28,288 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	264	0 95.00
101.00	10100	HOME HEALTH AGENCY	557,578	16,187	14,657	70,371	3,568 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	974,736	0	14,926	97,400	10,613 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,461,040	955,715	698,260	2,003,038	268,558 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,323	0	0	0 190.00
194.00	07950	IROQUOIS WOMENS HEALTH	377	11,351	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	51,523	0	4,249	5,719	0 194.01
194.02	07952	REFERENCE LAB	67,161	0	2,358	10,863	0 194.02
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	26,580,101	973,389	704,867	2,019,620	268,558 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	104,131					5.02
5.03	00550	DATA PROCESSING	200	828,717				5.03
5.04	01160	COMMUNICATIONS	0	0	307,325			5.04
5.05	00590	BUSINESS OFFICE	113	25,395	8,908	500,792		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	448	27,903	18,707	0	2,324,755	5.06
7.00	00700	OPERATION OF PLANT	1,564	24,726	10,690	0	1,256,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	185	3,624	891	0	74,182	8.00
9.00	00900	HOUSEKEEPING	2,100	38,984	891	0	417,476	9.00
10.00	01000	DIETARY	1,332	24,130	8,017	0	576,292	10.00
11.00	01100	CAFETERIA	671	19,965	0	0	132,454	11.00
13.00	01300	NURSING ADMINISTRATION	46	14,982	9,799	0	150,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,745	0	0	0	95,623	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93	26,232	31,178	0	290,222	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,225	81,107	61,462	19,368	1,654,523	30.00
44.00	04400	SKILLED NURSING FACILITY	3,003	90,827	10,690	29,642	1,902,726	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,217	37,112	32,959	34,903	1,286,868	50.00
53.00	05300	ANESTHESIOLOGY	330	0	0	940	11,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,347	38,478	19,598	47,622	1,304,110	54.00
57.00	05700	CT SCAN	0	5,740	0	59,746	531,768	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,792	0	11,902	300,555	58.00
60.00	06000	LABORATORY	36,665	43,996	14,253	88,217	1,931,072	60.00
65.00	06500	RESPIRATORY THERAPY	1,648	25,812	8,908	4,424	614,258	65.00
66.00	06600	PHYSICAL THERAPY	471	28,438	891	22,326	971,016	66.00
69.00	06900	ELECTROCARDIOLOGY	9	3,484	3,563	3,994	33,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,355	0	0	8,416	209,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,073	0	0	4,673	167,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,203	19,748	7,126	41,468	1,811,412	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	464	15,547	0	5,783	818,704	88.00
88.01	08801	RURAL HEALTH CLINIC II	218	13,024	0	3,376	343,139	88.01
88.02	08802	RURAL HEALTH CLINIC III	486	23,115	0	7,279	1,088,600	88.02
88.03	08803	RURAL HEALTH CLINIC IV	379	25,787	22,270	21,477	2,175,783	88.03
90.00	09000	CLINIC	1,306	19,289	15,144	6,038	455,582	90.00
91.00	09100	EMERGENCY	3,635	49,504	16,925	52,753	1,594,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	264	95.00
101.00	10100	HOME HEALTH AGENCY	840	21,646	0	6,653	691,500	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,512	46,247	0	19,792	1,168,226	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,883	798,634	302,870	500,792	26,385,391	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,782	0	8,105	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	7,695	0	0	19,423	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	248	22,138	1,782	0	85,659	194.01
194.02	07952	REFERENCE LAB	0	250	891	0	81,523	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,131	828,717	307,325	500,792	26,580,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
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Cost Center Description			OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	2,324,755					5.06
7.00	00700	OPERATION OF PLANT	120,467	1,377,365				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,110	30,424	111,716			8.00
9.00	00900	HOUSEKEEPING	40,013	8,872	0	466,361		9.00
10.00	01000	DIETARY	55,235	44,336	0	15,452	691,315	10.00
11.00	01100	CAFETERIA	12,695	13,793	0	4,807	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,443	14,098	0	4,914	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,165	19,960	0	6,957	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,816	17,838	0	6,217	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	158,578	123,140	17,274	42,918	88,041	30.00
44.00	04400	SKILLED NURSING FACILITY	182,367	129,851	44,895	45,257	490,591	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	123,340	216,068	6,215	75,308	635	50.00
53.00	05300	ANESTHESIOLOGY	1,136	1,459	0	508	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,992	60,741	8,313	21,170	0	54.00
57.00	05700	CT SCAN	50,967	12,122	0	4,225	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,807	0	0	0	0	58.00
60.00	06000	LABORATORY	185,084	46,696	148	16,275	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,874	27,214	0	9,485	0	65.00
66.00	06600	PHYSICAL THERAPY	93,067	163,961	12,065	57,146	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,178	9,655	0	3,365	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,050	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,089	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	173,615	46,696	0	16,275	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	78,469	51,962	0	18,110	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	32,888	37,227	0	12,975	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	104,337	56,484	0	19,687	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	208,538	32,002	0	11,154	0	88.03
90.00	09000	CLINIC	43,665	86,284	1,066	30,073	1,286	90.00
91.00	09100	EMERGENCY	152,836	61,285	21,740	21,360	7,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	25	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	66,277	31,166	0	10,862	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	111,969	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,306,092	1,343,334	111,716	454,500	588,522	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	777	12,175	0	4,243	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	1,862	21,856	0	7,618	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	8,210	0	0	0	102,793	194.01
194.02	07952	REFERENCE LAB	7,814	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,324,755	1,377,365	111,716	466,361	691,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	163,749					11.00
13.00	01300	NURSING ADMINISTRATION	1,056	185,199				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	131,705			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,339	0	128	348,560		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,129	61,987	4,438	13,480	2,185,508	30.00
44.00	04400	SKILLED NURSING FACILITY	29,581	0	4,131	20,631	2,850,030	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,508	28,660	15,433	24,293	1,786,328	50.00
53.00	05300	ANESTHESIOLOGY	0	0	454	655	16,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,677	0	4,605	33,146	1,569,754	54.00
57.00	05700	CT SCAN	6,339	0	0	41,584	647,005	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,056	0	0	8,284	338,702	58.00
60.00	06000	LABORATORY	15,847	0	50,445	61,400	2,306,967	60.00
65.00	06500	RESPIRATORY THERAPY	7,395	22,536	2,267	3,079	745,108	65.00
66.00	06600	PHYSICAL THERAPY	9,508	0	649	15,539	1,322,951	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	12	2,780	52,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	15,623	5,858	250,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,859	3,253	201,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,395	0	3,031	28,862	2,087,286	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	638	4,025	971,908	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	300	2,350	428,879	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	669	5,067	1,274,844	88.02
88.03	08803	RURAL HEALTH CLINIC IV	7,395	0	521	14,948	2,450,341	88.03
90.00	09000	CLINIC	4,226	13,905	1,796	4,203	642,086	90.00
91.00	09100	EMERGENCY	19,016	58,111	5,001	36,717	1,978,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	289	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	1,156	4,631	805,592	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	6,208	13,775	1,300,178	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,467	185,199	131,364	348,560	26,212,420	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	25,300	190.00
194.00	07950	IROQUOIS WOMENS HEALTH		0	0	0	50,759	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	3,169	0	341	0	200,172	194.01
194.02	07952	REFERENCE LAB	2,113	0	0	0	91,450	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,749	185,199	131,705	348,560	26,580,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	DATA PROCESSING			5.03
5.04	01160	COMMUNICATIONS			5.04
5.05	00590	BUSINESS OFFICE			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,185,508	30.00
44.00	04400	SKILLED NURSING FACILITY	0	2,850,030	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,786,328	50.00
53.00	05300	ANESTHESIOLOGY	0	16,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,569,754	54.00
57.00	05700	CT SCAN	0	647,005	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	338,702	58.00
60.00	06000	LABORATORY	0	2,306,967	60.00
65.00	06500	RESPIRATORY THERAPY	0	745,108	65.00
66.00	06600	PHYSICAL THERAPY	0	1,322,951	66.00
69.00	06900	ELECTROCARDIOLOGY	0	52,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	250,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	201,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,087,286	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	971,908	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	428,879	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,274,844	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,450,341	88.03
90.00	09000	CLINIC	0	642,086	90.00
91.00	09100	EMERGENCY	0	1,978,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	289	95.00
101.00	10100	HOME HEALTH AGENCY	0	805,592	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	1,300,178	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,212,420	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,300	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	50,759	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	200,172	194.01
194.02	07952	REFERENCE LAB	0	91,450	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	26,580,101	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,514	12,302	1,637	18,453	4.00
5.01	00570	ADMITTING	7,660	5,827	1,388	14,875	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,626	6,647	931	9,204	5.02
5.03	00550	DATA PROCESSING	0	17,020	44,755	61,775	5.03
5.04	01160	COMMUNICATIONS	0	1,226	0	1,226	5.04
5.05	00590	BUSINESS OFFICE	6,235	62,328	407	68,970	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	12,169	50,461	6,160	68,790	5.06
7.00	00700	OPERATION OF PLANT	1,780	102,230	85,310	189,320	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,801	88	15,889	8.00
9.00	00900	HOUSEKEEPING	0	4,608	98	4,706	9.00
10.00	01000	DIETARY	7,009	23,026	1,645	31,680	10.00
11.00	01100	CAFETERIA	0	7,163	0	7,163	11.00
13.00	01300	NURSING ADMINISTRATION	2,940	7,322	0	10,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,366	4,849	15,215	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,200	9,264	58	13,522	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,810	63,954	40,523	113,287	30.00
44.00	04400	SKILLED NURSING FACILITY	5,160	67,439	19,737	92,336	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,503	112,217	172,198	294,918	50.00
53.00	05300	ANESTHESIOLOGY	0	758	577	1,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,652	31,547	67,117	138,316	54.00
57.00	05700	CT SCAN	0	6,296	91,286	97,582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	290	290	58.00
60.00	06000	LABORATORY	53,105	24,252	17,699	95,056	60.00
65.00	06500	RESPIRATORY THERAPY	10,747	14,134	12,845	37,726	65.00
66.00	06600	PHYSICAL THERAPY	4,837	85,155	24,590	114,582	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,014	5,267	10,281	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,386	24,252	4,107	30,745	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,278	26,987	444	32,709	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,943	19,334	15,426	36,703	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,551	29,336	8,044	44,931	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,400	16,620	12,890	31,910	88.03
90.00	09000	CLINIC	13,586	44,813	3,032	61,431	90.00
91.00	09100	EMERGENCY	5,297	31,829	25,279	62,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,700	16,187	14,657	33,544	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	60,769	0	14,926	75,695	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,857	955,715	698,260	1,936,832	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,323	0	6,323	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	11,351	0	11,351	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	0	4,249	4,249	194.01
194.02	07952	REFERENCE LAB	0	0	2,358	2,358	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	282,857	973,389	704,867	1,961,113	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

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Cost Center Description			ADMITTING	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	15,163					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	9,291				5.02
5.03	00550	DATA PROCESSING	0	18	62,168			5.03
5.04	01160	COMMUNICATIONS	0	0	0	1,226		5.04
5.05	00590	BUSINESS OFFICE	0	10	1,905	36	71,339	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	40	2,093	75	0	5.06
7.00	00700	OPERATION OF PLANT	0	140	1,855	43	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17	272	4	0	8.00
9.00	00900	HOUSEKEEPING	0	187	2,925	4	0	9.00
10.00	01000	DIETARY	0	119	1,810	32	0	10.00
11.00	01100	CAFETERIA	0	60	1,498	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4	1,124	39	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	156	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8	1,968	124	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	587	288	6,084	243	2,760	30.00
44.00	04400	SKILLED NURSING FACILITY	898	268	6,815	43	4,223	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,057	1,001	2,784	131	4,973	50.00
53.00	05300	ANESTHESIOLOGY	28	29	0	0	134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,443	299	2,887	78	6,785	54.00
57.00	05700	CT SCAN	1,810	0	431	0	8,512	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	361	0	284	0	1,696	58.00
60.00	06000	LABORATORY	2,663	3,271	3,300	57	12,557	60.00
65.00	06500	RESPIRATORY THERAPY	134	147	1,936	36	630	65.00
66.00	06600	PHYSICAL THERAPY	676	42	2,133	4	3,181	66.00
69.00	06900	ELECTROCARDIOLOGY	121	1	261	14	569	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	255	1,013	0	0	1,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142	899	0	0	666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,256	197	1,481	28	5,908	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	175	41	1,166	0	824	88.00
88.01	08801	RURAL HEALTH CLINIC II	102	19	977	0	481	88.01
88.02	08802	RURAL HEALTH CLINIC III	221	43	1,734	0	1,037	88.02
88.03	08803	RURAL HEALTH CLINIC IV	651	34	1,934	89	3,060	88.03
90.00	09000	CLINIC	183	116	1,447	60	860	90.00
91.00	09100	EMERGENCY	1,598	324	3,714	68	7,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	202	75	1,624	0	948	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	600	403	3,469	0	2,820	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,163	9,269	59,911	1,208	71,339	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	577	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	22	1,661	7	0	194.01
194.02	07952	REFERENCE LAB	0	0	19	4	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,163	9,291	62,168	1,226	71,339	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	71,648					5.06
7.00	00700	OPERATION OF PLANT	3,713	195,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	219	4,318	20,777			8.00
9.00	00900	HOUSEKEEPING	1,233	1,259	0	10,702		9.00
10.00	01000	DIETARY	1,702	6,293	0	355	42,361	10.00
11.00	01100	CAFETERIA	391	1,958	0	110	0	11.00
13.00	01300	NURSING ADMINISTRATION	445	2,001	0	113	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	282	2,833	0	160	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	857	2,532	0	143	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,887	17,479	3,213	985	5,395	30.00
44.00	04400	SKILLED NURSING FACILITY	5,621	18,432	8,349	1,039	30,061	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,801	30,672	1,156	1,727	39	50.00
53.00	05300	ANESTHESIOLOGY	35	207	0	12	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,852	8,622	1,546	486	0	54.00
57.00	05700	CT SCAN	1,571	1,721	0	97	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	888	0	0	0	0	58.00
60.00	06000	LABORATORY	5,704	6,628	28	373	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,815	3,863	0	218	0	65.00
66.00	06600	PHYSICAL THERAPY	2,868	23,273	2,244	1,311	0	66.00
69.00	06900	ELECTROCARDIOLOGY	98	1,370	0	77	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	618	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	496	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,351	6,628	0	373	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,418	7,376	0	416	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,014	5,284	0	298	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,216	8,018	0	452	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,426	4,542	0	256	0	88.03
90.00	09000	CLINIC	1,346	12,248	198	690	79	90.00
91.00	09100	EMERGENCY	4,711	8,699	4,043	490	488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,043	4,424	0	249	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,451	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,073	190,680	20,777	10,430	36,062	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24	1,728	0	97	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	57	3,102	0	175	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	253	0	0	0	6,299	194.01
194.02	07952	REFERENCE LAB	241	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	71,648	195,510	20,777	10,702	42,361	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,339					11.00
13.00	01300	NURSING ADMINISTRATION	73	14,183				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	18,646			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	439	0	18	19,952		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,463	4,747	628	771	164,426	30.00
44.00	04400	SKILLED NURSING FACILITY	2,050	0	585	1,180	173,615	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	658	2,195	2,185	1,390	349,509	50.00
53.00	05300	ANESTHESIOLOGY	0	0	64	37	1,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878	0	652	1,896	168,269	54.00
57.00	05700	CT SCAN	439	0	0	2,379	114,789	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73	0	0	474	4,159	58.00
60.00	06000	LABORATORY	1,097	0	7,141	3,527	142,260	60.00
65.00	06500	RESPIRATORY THERAPY	512	1,726	321	176	49,827	65.00
66.00	06600	PHYSICAL THERAPY	658	0	92	889	152,857	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2	159	12,957	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,212	335	5,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,962	186	4,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	512	0	429	1,651	55,150	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	90	230	46,246	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	43	134	45,318	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	95	290	61,039	88.02
88.03	08803	RURAL HEALTH CLINIC IV	512	0	74	855	51,675	88.03
90.00	09000	CLINIC	293	1,065	254	240	80,844	90.00
91.00	09100	EMERGENCY	1,317	4,450	708	2,100	104,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	3	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	164	265	44,181	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	879	788	88,995	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,974	14,183	18,598	19,952	1,921,995	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,179	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	15,262	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	219	0	48	0	12,810	194.01
194.02	07952	REFERENCE LAB	146	0	0	0	2,867	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,339	14,183	18,646	19,952	1,961,113	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	DATA PROCESSING			5.03
5.04	01160	COMMUNICATIONS			5.04
5.05	00590	BUSINESS OFFICE			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	164,426	30.00
44.00	04400	SKILLED NURSING FACILITY	0	173,615	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	349,509	50.00
53.00	05300	ANESTHESIOLOGY	0	1,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	168,269	54.00
57.00	05700	CT SCAN	0	114,789	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,159	58.00
60.00	06000	LABORATORY	0	142,260	60.00
65.00	06500	RESPIRATORY THERAPY	0	49,827	65.00
66.00	06600	PHYSICAL THERAPY	0	152,857	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,957	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,150	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	46,246	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	45,318	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	61,039	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	51,675	88.03
90.00	09000	CLINIC	0	80,844	90.00
91.00	09100	EMERGENCY	0	104,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	3	95.00
101.00	10100	HOME HEALTH AGENCY	0	44,181	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	88,995	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,921,995	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,179	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	15,262	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	12,810	194.01
194.02	07952	REFERENCE LAB	0	2,867	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,961,113	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	141,319					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,354,505				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,786	3,146	13,751,942			4.00
5.01	00570	ADMITTING	846	2,667	214,503	51,257,173		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	965	1,789	64,870	0	1,557,014	5.02
5.03	00550	DATA PROCESSING	2,471	86,003	279,079	0	2,988	5.03
5.04	01160	COMMUNICATIONS	178	0	0	0	0	5.04
5.05	00590	BUSINESS OFFICE	9,049	783	311,123	0	1,691	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	7,326	11,838	484,411	0	6,699	5.06
7.00	00700	OPERATION OF PLANT	14,842	163,936	327,301	0	23,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	169	43,451	0	2,767	8.00
9.00	00900	HOUSEKEEPING	669	189	289,106	0	31,396	9.00
10.00	01000	DIETARY	3,343	3,162	275,663	0	19,922	10.00
11.00	01100	CAFETERIA	1,040	0	118,197	0	10,035	11.00
13.00	01300	NURSING ADMINISTRATION	1,063	0	91,074	0	689	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	9,318	0	0	26,086	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	112	254,330	0	1,387	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,285	77,871	1,198,722	1,982,406	48,227	30.00
44.00	04400	SKILLED NURSING FACILITY	9,791	37,928	1,277,801	3,034,026	44,895	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,292	330,898	612,823	3,572,446	167,725	50.00
53.00	05300	ANESTHESIOLOGY	110	1,108	0	96,253	4,935	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,580	128,976	394,359	4,874,359	50,049	54.00
57.00	05700	CT SCAN	914	175,420	184,382	6,115,267	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	557	69,171	1,218,233	0	58.00
60.00	06000	LABORATORY	3,521	34,012	639,587	9,027,996	548,215	60.00
65.00	06500	RESPIRATORY THERAPY	2,052	24,683	437,219	452,855	24,637	65.00
66.00	06600	PHYSICAL THERAPY	12,363	47,253	673,920	2,285,169	7,050	66.00
69.00	06900	ELECTROCARDIOLOGY	728	10,122	3,259	408,848	133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	861,413	169,790	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	478,314	150,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,521	7,893	440,218	4,244,416	32,943	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,918	854	597,159	591,927	6,939	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,807	29,643	195,772	345,583	3,264	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,259	15,457	746,624	745,076	7,268	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,413	24,770	992,374	2,198,304	5,665	88.03
90.00	09000	CLINIC	6,506	5,827	248,960	618,026	19,524	90.00
91.00	09100	EMERGENCY	4,621	48,577	1,029,402	5,399,519	54,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,797	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,350	28,165	479,165	680,986	12,566	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	28,682	663,213	2,025,751	67,469	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,753	1,341,808	13,639,035	51,257,173	1,553,306	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	1,648	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	8,165	38,939	0	3,708	194.01
194.02	07952	REFERENCE LAB	0	4,532	73,968	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	973,389	704,867	2,019,620	268,558	104,131	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.887885	0.520387	0.146861	0.005239	0.066879	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,453	15,163	9,291	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001342	0.000296	0.005967	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		DATA PROCESSING (TIME SPENT)	COMMUNICATIONS (# OF PHONES)	BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING	592,197				5.03
5.04	01160	COMMUNICATIONS	0	345			5.04
5.05	00590	BUSINESS OFFICE	18,147	10	51,257,173		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	19,939	21	0	-2,324,755	5.06
7.00	00700	OPERATION OF PLANT	17,669	12	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,590	1	0	0	8.00
9.00	00900	HOUSEKEEPING	27,858	1	0	0	9.00
10.00	01000	DIETARY	17,243	9	0	0	10.00
11.00	01100	CAFETERIA	14,267	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,706	11	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,745	35	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,959	69	1,982,406	0	30.00
44.00	04400	SKILLED NURSING FACILITY	64,903	12	3,034,026	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,520	37	3,572,446	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	96,253	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,496	22	4,874,359	0	54.00
57.00	05700	CT SCAN	4,102	0	6,115,267	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,710	0	1,218,233	0	58.00
60.00	06000	LABORATORY	31,439	16	9,027,996	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,445	10	452,855	0	65.00
66.00	06600	PHYSICAL THERAPY	20,322	1	2,285,169	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,490	4	408,848	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	861,413	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	478,314	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,112	8	4,244,416	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,110	0	591,927	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,307	0	345,583	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,518	0	745,076	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	18,427	25	2,198,304	0	88.03
90.00	09000	CLINIC	13,784	17	618,026	0	90.00
91.00	09100	EMERGENCY	35,375	19	5,399,519	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	15,468	0	680,986	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	33,048	0	2,025,751	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	570,699	340	51,257,173	-2,324,755	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	5,499	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	15,820	2	0	0	194.01
194.02	07952	REFERENCE LAB	179	1	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	828,717	307,325	500,792	2,324,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.399394	890.797101	0.009770	0.095845	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,168	1,226	71,339	71,648	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.104979	3.553623	0.001392	0.002954	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING					5.03
5.04	01160	COMMUNICATIONS					5.04
5.05	00590	BUSINESS OFFICE					5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	103,856				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	128,340			8.00
9.00	00900	HOUSEKEEPING	669	0	100,893		9.00
10.00	01000	DIETARY	3,343	0	3,343	41,381	10.00
11.00	01100	CAFETERIA	1,040	0	1,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,063	0	1,063	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	0	1,505	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	0	1,345	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,285	19,845	9,285	5,270	30.00
44.00	04400	SKILLED NURSING FACILITY	9,791	51,575	9,791	29,366	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,292	7,140	16,292	38	50.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,580	9,550	4,580	0	54.00
57.00	05700	CT SCAN	914	0	914	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	3,521	170	3,521	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,052	0	2,052	0	65.00
66.00	06600	PHYSICAL THERAPY	12,363	13,860	12,363	0	66.00
69.00	06900	ELECTROCARDIOLOGY	728	0	728	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,521	0	3,521	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,918	0	3,918	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,807	0	2,807	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,259	0	4,259	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,413	0	2,413	0	88.03
90.00	09000	CLINIC	6,506	1,225	6,506	77	90.00
91.00	09100	EMERGENCY	4,621	24,975	4,621	477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,350	0	2,350	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,290	128,340	98,327	35,228	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	918	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	1,648	0	1,648	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	0	0	6,153	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,377,365	111,716	466,361	691,315	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.262257	0.870469	4.622333	16.706097	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	195,510	20,777	10,702	42,361	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.882510	0.161890	0.106073	1.023682	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet B-1
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00550	DATA PROCESSING				5.03
5.04	01160	COMMUNICATIONS				5.04
5.05	00590	BUSINESS OFFICE				5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	122,077			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,431,357		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,387	51,257,173	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,859	48,227	1,982,406	30.00
44.00	04400	SKILLED NURSING FACILITY	0	44,895	3,034,026	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,892	167,725	3,572,446	50.00
53.00	05300	ANESTHESIOLOGY	0	4,935	96,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,049	4,874,359	54.00
57.00	05700	CT SCAN	0	0	6,115,267	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,218,233	58.00
60.00	06000	LABORATORY	0	548,215	9,027,996	60.00
65.00	06500	RESPIRATORY THERAPY	14,855	24,637	452,855	65.00
66.00	06600	PHYSICAL THERAPY	0	7,050	2,285,169	66.00
69.00	06900	ELECTROCARDIOLOGY	0	133	408,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	169,790	861,413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	150,613	478,314	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,943	4,244,416	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,939	591,927	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,264	345,583	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	7,268	745,076	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	5,665	2,198,304	88.03
90.00	09000	CLINIC	9,166	19,524	618,026	90.00
91.00	09100	EMERGENCY	38,305	54,355	5,399,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	12,566	680,986	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	67,469	2,025,751	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,077	1,427,649	51,257,173	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	3,708	0	194.01
194.02	07952	REFERENCE LAB	0	0	0	194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	185,199	131,705	348,560	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.517067	0.092014	0.006800	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,183	18,646	19,952	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.116181	0.013027	0.000389	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: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 8:50 am

			Title XVIII	Hospital	PPS			
	Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,185,508		2,185,508	0	2,185,508	30.00
44.00	04400	SKILLED NURSING FACILITY	2,850,030		2,850,030	0	2,850,030	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,786,328		1,786,328	0	1,786,328	50.00
53.00	05300	ANESTHESIOLOGY	16,069		16,069	0	16,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,569,754		1,569,754	4,302	1,574,056	54.00
57.00	05700	CT SCAN	647,005		647,005	0	647,005	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	338,702		338,702	0	338,702	58.00
60.00	06000	LABORATORY	2,306,967		2,306,967	0	2,306,967	60.00
65.00	06500	RESPIRATORY THERAPY	745,108	0	745,108	0	745,108	65.00
66.00	06600	PHYSICAL THERAPY	1,322,951	0	1,322,951	0	1,322,951	66.00
69.00	06900	ELECTROCARDIOLOGY	52,148		52,148	0	52,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,726		250,726	0	250,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,066		201,066	0	201,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,087,286		2,087,286	0	2,087,286	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	971,908		971,908	0	971,908	88.00
88.01	08801	RURAL HEALTH CLINIC II	428,879		428,879	0	428,879	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,274,844		1,274,844	0	1,274,844	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,450,341		2,450,341	0	2,450,341	88.03
90.00	09000	CLINIC	642,086		642,086	0	642,086	90.00
91.00	09100	EMERGENCY	1,978,655		1,978,655	0	1,978,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	699,109		699,109	0	699,109	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	289		289	0	289	95.00
101.00	10100	HOME HEALTH AGENCY	805,592		805,592	0	805,592	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,300,178		1,300,178		1,300,178	116.00
200.00		Subtotal (see instructions)	26,911,529	0	26,911,529	4,302	26,915,831	200.00
201.00		Less Observation Beds	699,109		699,109		699,109	201.00
202.00		Total (see instructions)	26,212,420	0	26,212,420	4,302	26,216,722	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 8:50 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,097,846		1,097,846		30.00
44.00	04400	SKILLED NURSING FACILITY	3,034,026		3,034,026		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	556,306	3,016,140	3,572,446	0.500029	0.000000
53.00	05300	ANESTHESIOLOGY	18,216	78,037	96,253	0.166945	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,414	4,590,945	4,874,359	0.322043	0.000000
57.00	05700	CT SCAN	597,003	5,518,264	6,115,267	0.105802	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,672	1,189,561	1,218,233	0.278027	0.000000
60.00	06000	LABORATORY	829,680	8,198,316	9,027,996	0.255535	0.000000
65.00	06500	RESPIRATORY THERAPY	70,296	382,559	452,855	1.645357	0.000000
66.00	06600	PHYSICAL THERAPY	185,190	2,099,979	2,285,169	0.578929	0.000000
69.00	06900	ELECTROCARDIOLOGY	56,188	352,660	408,848	0.127549	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	322,864	538,549	861,413	0.291064	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,982	367,332	478,314	0.420364	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,019,896	3,224,520	4,244,416	0.491772	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	591,927	591,927		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	345,583	345,583		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	745,076	745,076		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,508,923	689,381	2,198,304		88.03
90.00	09000	CLINIC	5,298	612,728	618,026	1.038930	0.000000
91.00	09100	EMERGENCY	533,069	4,866,450	5,399,519	0.366450	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	125,488	759,072	884,560	0.790347	0.000000
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
101.00	10100	HOME HEALTH AGENCY	0	680,986	680,986		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	2,025,751	2,025,751		116.00
200.00		Subtotal (see instructions)	10,383,357	40,873,816	51,257,173		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,383,357	40,873,816	51,257,173		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.500029			50.00
53.00	05300	ANESTHESIOLOGY	0.166945			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.322926			54.00
57.00	05700	CT SCAN	0.105802			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278027			58.00
60.00	06000	LABORATORY	0.255535			60.00
65.00	06500	RESPIRATORY THERAPY	1.645357			65.00
66.00	06600	PHYSICAL THERAPY	0.578929			66.00
69.00	06900	ELECTROCARDIOLOGY	0.127549			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.420364			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491772			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	1.038930			90.00
91.00	09100	EMERGENCY	0.366450			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.790347			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
4/26/2021 8:50 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 8:50 am

			Title XIX		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,097,846		1,097,846		30.00
44.00	04400	SKILLED NURSING FACILITY	3,034,026		3,034,026		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	556,306	3,016,140	3,572,446	0.500029	50.00
53.00	05300	ANESTHESIOLOGY	18,216	78,037	96,253	0.166945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,414	4,590,945	4,874,359	0.322043	54.00
57.00	05700	CT SCAN	597,003	5,518,264	6,115,267	0.105802	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,672	1,189,561	1,218,233	0.278027	58.00
60.00	06000	LABORATORY	829,680	8,198,316	9,027,996	0.255535	60.00
65.00	06500	RESPIRATORY THERAPY	70,296	382,559	452,855	1.645357	65.00
66.00	06600	PHYSICAL THERAPY	185,190	2,099,979	2,285,169	0.578929	66.00
69.00	06900	ELECTROCARDIOLOGY	56,188	352,660	408,848	0.127549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	322,864	538,549	861,413	0.291064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,982	367,332	478,314	0.420364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,019,896	3,224,520	4,244,416	0.491772	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	591,927	591,927	1.641939	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	345,583	345,583	1.241030	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	745,076	745,076	1.711025	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,508,923	689,381	2,198,304	1.114651	88.03
90.00	09000	CLINIC	5,298	612,728	618,026	1.038930	90.00
91.00	09100	EMERGENCY	533,069	4,866,450	5,399,519	0.366450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	125,488	759,072	884,560	0.790347	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	680,986	680,986		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	2,025,751	2,025,751		116.00
200.00		Subtotal (see instructions)	10,383,357	40,873,816	51,257,173		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,383,357	40,873,816	51,257,173		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.500029			50.00
53.00	05300	ANESTHESIOLOGY	0.166945			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.322926			54.00
57.00	05700	CT SCAN	0.105802			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278027			58.00
60.00	06000	LABORATORY	0.255535			60.00
65.00	06500	RESPIRATORY THERAPY	1.645357			65.00
66.00	06600	PHYSICAL THERAPY	0.578929			66.00
69.00	06900	ELECTROCARDIOLOGY	0.127549			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.420364			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491772			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.641939			88.00
88.01	08801	RURAL HEALTH CLINIC II	1.241030			88.01
88.02	08802	RURAL HEALTH CLINIC III	1.711025			88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.114651			88.03
90.00	09000	CLINIC	1.038930			90.00
91.00	09100	EMERGENCY	0.366450			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.790347			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description			Title XIX		Hospital		PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,786,328	349,509	1,436,819	0	0	50.00
53.00	05300	ANESTHESIOLOGY	16,069	1,881	14,188	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,569,754	168,269	1,401,485	0	0	54.00
57.00	05700	CT SCAN	647,005	114,789	532,216	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	338,702	4,159	334,543	0	0	58.00
60.00	06000	LABORATORY	2,306,967	142,260	2,164,707	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	745,108	49,827	695,281	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,322,951	152,857	1,170,094	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	52,148	12,957	39,191	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,726	5,632	245,094	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,066	4,351	196,715	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,087,286	55,150	2,032,136	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	971,908	46,246	925,662	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	428,879	45,318	383,561	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,274,844	61,039	1,213,805	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,450,341	51,675	2,398,666	0	0	88.03
90.00	09000	CLINIC	642,086	80,844	561,242	0	0	90.00
91.00	09100	EMERGENCY	1,978,655	104,012	1,874,643	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	699,109	52,597	646,512	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	289	3	286	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	805,592	44,181	761,411	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,300,178	88,995	1,211,183	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	21,875,991	1,636,551	20,239,440	0	0	200.00
201.00		Less Observation Beds	699,109	52,597	646,512	0	0	201.00
202.00		Total (line 200 minus line 201)	21,176,882	1,583,954	19,592,928	0	0	202.00

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

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,786,328	3,572,446	0.500029		50.00
53.00	05300 ANESTHESIOLOGY	16,069	96,253	0.166945		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,569,754	4,874,359	0.322043		54.00
57.00	05700 CT SCAN	647,005	6,115,267	0.105802		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	338,702	1,218,233	0.278027		58.00
60.00	06000 LABORATORY	2,306,967	9,027,996	0.255535		60.00
65.00	06500 RESPIRATORY THERAPY	745,108	452,855	1.645357		65.00
66.00	06600 PHYSICAL THERAPY	1,322,951	2,285,169	0.578929		66.00
69.00	06900 ELECTROCARDIOLOGY	52,148	408,848	0.127549		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	250,726	861,413	0.291064		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	201,066	478,314	0.420364		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,087,286	4,244,416	0.491772		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	971,908	591,927	1.641939		88.00
88.01	08801 RURAL HEALTH CLINIC II	428,879	345,583	1.241030		88.01
88.02	08802 RURAL HEALTH CLINIC III	1,274,844	745,076	1.711025		88.02
88.03	08803 RURAL HEALTH CLINIC IV	2,450,341	2,198,304	1.114651		88.03
90.00	09000 CLINIC	642,086	618,026	1.038930		90.00
91.00	09100 EMERGENCY	1,978,655	5,399,519	0.366450		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	699,109	884,560	0.790347		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	289	0	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY	805,592	680,986	1.182979		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	1,300,178	2,025,751	0.641825		116.00
200.00	Subtotal (sum of lines 50 thru 199)	21,875,991	47,125,301			200.00
201.00	Less Observation Beds	699,109	0			201.00
202.00	Total (line 200 minus line 201)	21,176,882	47,125,301			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/26/2021 8:50 am

			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	164,426	0	164,426	1,388	118.46	30.00
44.00	SKILLED NURSING FACILITY	173,615		173,615	10,434	16.64	44.00
200.00	Total (lines 30 through 199)	338,041		338,041	11,822		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	662	78,421				30.00
44.00	SKILLED NURSING FACILITY	835	13,894				44.00
200.00	Total (lines 30 through 199)	1,497	92,315				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/26/2021 8:50 am

				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	349,509	3,572,446	0.097835	399,030	39,039	50.00
53.00	05300	ANESTHESIOLOGY	1,881	96,253	0.019542	16,119	315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,269	4,874,359	0.034521	268,440	9,267	54.00
57.00	05700	CT SCAN	114,789	6,115,267	0.018771	523,003	9,817	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,159	1,218,233	0.003414	18,252	62	58.00
60.00	06000	LABORATORY	142,260	9,027,996	0.015758	784,953	12,369	60.00
65.00	06500	RESPIRATORY THERAPY	49,827	452,855	0.110029	57,921	6,373	65.00
66.00	06600	PHYSICAL THERAPY	152,857	2,285,169	0.066891	58,100	3,886	66.00
69.00	06900	ELECTROCARDIOLOGY	12,957	408,848	0.031691	50,078	1,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,632	861,413	0.006538	313,512	2,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,351	478,314	0.009097	104,215	948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,150	4,244,416	0.012994	798,896	10,381	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	46,246	591,927	0.078128	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	45,318	345,583	0.131135	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	61,039	745,076	0.081923	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	51,675	2,198,304	0.023507	0	0	88.03
90.00	09000	CLINIC	80,844	618,026	0.130810	3,769	493	90.00
91.00	09100	EMERGENCY	104,012	5,399,519	0.019263	408,505	7,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	52,597	884,560	0.059461	109,704	6,523	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,503,372	44,418,564		3,914,497	110,979	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0167		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/26/2021 8:50 am		
					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	
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00	
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	1,388	0.00	662		30.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	10,434	0.00	835		44.00	
200.00		Total (lines 30 through 199)		0	0	11,822		1,497		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
44.00	04400	SKILLED NURSING FACILITY		0						44.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

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

Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

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

Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

			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	3,572,446	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	96,253	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,874,359	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	6,115,267	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,218,233	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	9,027,996	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	452,855	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,285,169	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	408,848	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	861,413	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	478,314	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,244,416	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	591,927	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	345,583	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	745,076	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,198,304	0.000000	88.03
90.00	09000	CLINIC	0	0	0	618,026	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,399,519	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	884,560	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	44,418,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

					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
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	399,030	0	1,077,780	0	50.00		
53.00	05300	ANESTHESIOLOGY	0.000000	16,119	0	17,912	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	268,440	0	1,538,906	0	54.00		
57.00	05700	CT SCAN	0.000000	523,003	0	1,982,006	0	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	18,252	0	440,789	0	58.00		
60.00	06000	LABORATORY	0.000000	784,953	0	1,233,984	0	60.00		
65.00	06500	RESPIRATORY THERAPY	0.000000	57,921	0	176,050	0	65.00		
66.00	06600	PHYSICAL THERAPY	0.000000	58,100	0	6,763	0	66.00		
69.00	06900	ELECTROCARDIOLOGY	0.000000	50,078	0	143,604	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	313,512	0	212,946	0	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	104,215	0	74,940	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	798,896	0	1,275,538	0	73.00		
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00		
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01		
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02		
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03		
90.00	09000	CLINIC	0.000000	3,769	0	287,711	0	90.00		
91.00	09100	EMERGENCY	0.000000	408,505	0	1,453,020	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	109,704	0	380,774	0	92.00		
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00		
200.00		Total (lines 50 through 199)		3,914,497	0	10,302,723	0	200.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/26/2021 8:50 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.500029	1,077,780	0	0	538,921	50.00	
53.00	05300	ANESTHESIOLOGY	0.166945	17,912	0	0	2,990	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.322043	1,538,906	0	0	495,594	54.00	
57.00	05700	CT SCAN	0.105802	1,982,006	0	0	209,700	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278027	440,789	0	0	122,551	58.00	
60.00	06000	LABORATORY	0.255535	1,233,984	0	0	315,326	60.00	
65.00	06500	RESPIRATORY THERAPY	1.645357	176,050	0	0	289,665	65.00	
66.00	06600	PHYSICAL THERAPY	0.578929	6,763	0	0	3,915	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.127549	143,604	0	0	18,317	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064	212,946	0	0	61,981	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.420364	74,940	0	0	31,502	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491772	1,275,538	0	34,994	627,274	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC						88.00	
88.01	08801	RURAL HEALTH CLINIC II						88.01	
88.02	08802	RURAL HEALTH CLINIC III						88.02	
88.03	08803	RURAL HEALTH CLINIC IV						88.03	
90.00	09000	CLINIC	1.038930	287,711	0	0	298,912	90.00	
91.00	09100	EMERGENCY	0.366450	1,453,020	0	89	532,459	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.790347	380,774	0	0	300,944	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
200.00		Subtotal (see instructions)		10,302,723	0	35,083	3,850,051	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		10,302,723	0	35,083	3,850,051	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/26/2021 8:50 am

				Title XVIII	Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,209		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	33		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	17,242		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	17,242		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/26/2021 8:50 am

			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	164,426	0	164,426	1,388	118.46	30.00
44.00	SKILLED NURSING FACILITY	173,615		173,615	10,434	16.64	44.00
200.00	Total (lines 30 through 199)	338,041		338,041	11,822		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	5	592				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	5	592	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/26/2021 8:50 am

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	349,509	3,572,446	0.097835	0	50.00
53.00	05300	ANESTHESIOLOGY	1,881	96,253	0.019542	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,269	4,874,359	0.034521	628	54.00
57.00	05700	CT SCAN	114,789	6,115,267	0.018771	2,832	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,159	1,218,233	0.003414	0	58.00
60.00	06000	LABORATORY	142,260	9,027,996	0.015758	6,554	60.00
65.00	06500	RESPIRATORY THERAPY	49,827	452,855	0.110029	0	65.00
66.00	06600	PHYSICAL THERAPY	152,857	2,285,169	0.066891	0	66.00
69.00	06900	ELECTROCARDIOLOGY	12,957	408,848	0.031691	364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,632	861,413	0.006538	111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,351	478,314	0.009097	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,150	4,244,416	0.012994	5,222	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	46,246	591,927	0.078128	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	45,318	345,583	0.131135	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	61,039	745,076	0.081923	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	51,675	2,198,304	0.023507	0	88.03
90.00	09000	CLINIC	80,844	618,026	0.130810	0	90.00
91.00	09100	EMERGENCY	104,012	5,399,519	0.019263	3,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	52,597	884,560	0.059461	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	1,503,372	44,418,564		19,403	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0167		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/26/2021 8:50 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,388	0.00	5	0	30.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	10,434	0.00	0	0	44.00	
200.00		Total (lines 30 through 199)		0	0	11,822		5	0	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
44.00	04400	SKILLED NURSING FACILITY	0							44.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

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

Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

			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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Title XIX		Hospital		PPS	
		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	3,572,446	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	96,253	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,874,359	0.000000 54.00
57.00	05700	CT SCAN	0	0	0	6,115,267	0.000000 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,218,233	0.000000 58.00
60.00	06000	LABORATORY	0	0	0	9,027,996	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	452,855	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,285,169	0.000000 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	408,848	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	861,413	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	478,314	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,244,416	0.000000 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	591,927	0.000000 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	345,583	0.000000 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	745,076	0.000000 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,198,304	0.000000 88.03
90.00	09000	CLINIC	0	0	0	618,026	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	5,399,519	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	884,560	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	44,418,564	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 8:50 am

				Title XIX		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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	628	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	2,832	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	6,554	0	0	0	60.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000	364	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	111	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	5,222	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,692	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		19,403	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/26/2021 8:50 am

			Title XIX		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.500029	0	75,118	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.166945	0	2,851	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.322043	0	92,755	0	0	54.00
57.00	05700	CT SCAN	0.105802	0	145,770	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278027	0	44,555	0	0	58.00
60.00	06000	LABORATORY	0.255535	0	123,636	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.645357	0	3,378	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.578929	0	12,708	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.127549	0	12,427	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064	0	20,196	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.420364	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491772	0	37,521	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	1.038930	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.366450	0	233,453	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.790347	0	40,308	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	844,676	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	844,676	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/26/2021 8:50 am

			Title XIX		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	37,561	0		50.00
53.00	05300	ANESTHESIOLOGY	476	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,871	0		54.00
57.00	05700	CT SCAN	15,423	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,387	0		58.00
60.00	06000	LABORATORY	31,593	0		60.00
65.00	06500	RESPIRATORY THERAPY	5,558	0		65.00
66.00	06600	PHYSICAL THERAPY	7,357	0		66.00
69.00	06900	ELECTROCARDIOLOGY	1,585	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,878	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,452	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	85,549	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	31,857	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	283,547	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	283,547	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 8:50 am
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,388 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,388 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)			944 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)			662 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			159.97 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.71 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,185,508 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,185,508 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,185,508 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)			1,574.57 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,042,365 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,042,365 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
4/26/2021 8:50 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,453,473 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,495,838 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)					78,421 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					110,979 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					189,400 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,306,438 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)					444 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,574.57 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					699,109 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Title XVIII		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	164,426	2,185,508	0.075235	699,109	52,597
91.00	Nursing School cost	0	2,185,508	0.000000	699,109	0
92.00	Allied health cost	0	2,185,508	0.000000	699,109	0
93.00	All other Medical Education	0	2,185,508	0.000000	699,109	0

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2019	Worksheet D-1	
		Component CCN: 14-6049	To 09/30/2020	Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,434	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,434	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		10,434	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)		835	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)		2,850,030	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		0	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,850,030	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,850,030	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 8:50 am
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				2,850,030	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				273.15	71.00
72.00 Program routine service cost (line 9 x line 71)				228,080	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				228,080	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				228,080	83.00
84.00 Program inpatient ancillary services (see instructions)				86,429	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				314,509	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0167 Component CCN: 14-6049		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/26/2021 8:50 am
			Title XVIII		Skilled Nursing Facility		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 8:50 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,388 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,388 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)			944 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)			5 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			159.97 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.71 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,185,508 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,185,508 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,185,508 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)			1,574.57 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			7,873 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)			7,873 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Title XIX		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,177	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,050	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)					592	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					330	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					922	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,128	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)					444	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,574.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					699,109	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
4/26/2021 8:50 am

		Title XIX		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	164,426	2,185,508	0.075235	699,109	52,597	90.00
91.00 Nursing School cost	0	2,185,508	0.000000	699,109	0	91.00
92.00 Allied health cost	0	2,185,508	0.000000	699,109	0	92.00
93.00 All other Medical Education	0	2,185,508	0.000000	699,109	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/26/2021 8:50 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		777,807		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.500029	399,030	199,527	50.00
53.00	05300 ANESTHESIOLOGY	0.166945	16,119	2,691	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	268,440	86,686	54.00
57.00	05700 CT SCAN	0.105802	523,003	55,335	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.278027	18,252	5,075	58.00
60.00	06000 LABORATORY	0.255535	784,953	200,583	60.00
65.00	06500 RESPIRATORY THERAPY	1.645357	57,921	95,301	65.00
66.00	06600 PHYSICAL THERAPY	0.578929	58,100	33,636	66.00
69.00	06900 ELECTROCARDIOLOGY	0.127549	50,078	6,387	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064	313,512	91,252	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.420364	104,215	43,808	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.491772	798,896	392,875	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000 CLINIC	1.038930	3,769	3,916	90.00
91.00	09100 EMERGENCY	0.366450	408,505	149,697	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.790347	109,704	86,704	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,914,497	1,453,473	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,914,497		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3	
		Component CCN: 14-6049		Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.500029	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.166945	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	2,636	851	54.00
57.00	05700 CT SCAN	0.105802	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.278027	0	0	58.00
60.00	06000 LABORATORY	0.255535	2,968	758	60.00
65.00	06500 RESPIRATORY THERAPY	1.645357	1,049	1,726	65.00
66.00	06600 PHYSICAL THERAPY	0.578929	111,763	64,703	66.00
69.00	06900 ELECTROCARDIOLOGY	0.127549	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064	885	258	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.420364	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.491772	34,669	17,049	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000 CLINIC	1.038930	1,043	1,084	90.00
91.00	09100 EMERGENCY	0.366450	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.790347	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		155,013	86,429	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)		155,013		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/26/2021 8:50 am	
		Title XIX	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		7,134		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.500029	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.166945	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	628	203	54.00
57.00	05700 CT SCAN	0.105802	2,832	300	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.278027	0	0	58.00
60.00	06000 LABORATORY	0.255535	6,554	1,675	60.00
65.00	06500 RESPIRATORY THERAPY	1.645357	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.578929	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.127549	364	46	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291064	111	32	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.420364	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.491772	5,222	2,568	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.641939	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.241030	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1.711025	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	1.114651	0	0	88.03
90.00	09000 CLINIC	1.038930	0	0	90.00
91.00	09100 EMERGENCY	0.366450	3,692	1,353	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.790347	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		19,403	6,177	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)		19,403		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/26/2021 8:50 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,596,977	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)		23,553	2.04
3.00	Managed Care Simulated Payments		38,029	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		23.79	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)		5.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.94	31.00
32.00	Sum of lines 30 and 31		20.31	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.97	33.00
34.00	Disproportionate share adjustment (see instructions)		23,835	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/26/2021 8:50 am	
		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	0.000037523		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	313,340	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	313,340	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		313,340		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 an 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	1,957,705			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	2,082,149			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			2,082,149	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			127,159	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 intructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,209,308	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,209,308	61.00
62.00	Deductibles billed to program beneficiaries			246,224	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1,963,084	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-3,354	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/26/2021 8:50 am
		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)	2020	568,729	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,528,459	71.00
71.01	Sequestration adjustment (see instructions)		29,330	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		2,535,520	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)		-36,391	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		19,582	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/26/2021 8:50 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,596,977	0		1,596,977	1,596,977	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	23,553	0		23,553	23,553	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	38,029	0	0	38,029	38,029	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0597	0.0597	0.0597	0.0597		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	23,835	0	0	23,835	23,835	11.00
11.01	Uncompensated care payments	36.00	313,340	0	0	313,340	313,340	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,957,705	0	0	1,957,705	1,957,705	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,082,149	0	0	2,082,149	2,082,149	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,082,149	0	0	2,082,149	2,082,149	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	127,159	0	0	127,159	127,159	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/26/2021 8:50 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	2,209,308	2,209,308
		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	125,522	0	0	125,522	125,522
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	1,637	0	0	1,637	1,637
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	127,159	0	0	127,159	127,159
		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	0.257424	
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				568,729	568,729
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/26/2021 8:50 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,596,977		1,596,977	1,596,977	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	23,553		23,553	23,553	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	38,029	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	0.0597	0.0597	0.0597		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	23,835	0	23,835	23,835	11.00
11.01	Uncompensated care payments	36.00	313,340	0	313,340	313,340	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,957,705	0	1,957,705	1,957,705	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,082,149	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,082,149	0	2,082,149	2,082,149	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	127,159	0	127,159	127,159	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,209,308	2,209,308	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/26/2021 8:50 am

		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	125,522	0	125,522	125,522	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	1,637	0	1,637	1,637	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	127,159	0	127,159	127,159	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	568,729		568,729	568,729	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-3,354	0	-3,354	-3,354	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/26/2021 8:50 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		17,242	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,850,051	2.00
3.00	OPPS payments		2,142,028	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		17,242	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		35,083	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)		35,083	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		35,083	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,841	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)		17,242	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)		2,142,028	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)		432,837	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)		1,726,433	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)		1,726,433	30.00
31.00	Primary payer payments		152	31.00
32.00	Subtotal (line 30 minus line 31)		1,726,281	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,726,281	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)		1,726,281	40.00
40.01	Sequestration adjustment (see instructions)		20,025	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		1,723,239	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)		-16,983	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		15,046	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/26/2021 8:50 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,535,520		1,723,239	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)		2,535,520		1,723,239	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		36,391		16,983	6.02
7.00	Total Medicare program liability (see instructions)		2,499,129		1,706,256	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0167 Component CCN: 14-6049		Period: From 10/01/2019 To 09/30/2020		Worksheet E-1 Part I Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		347,944		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)		347,944		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)		347,944		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/26/2021 8:50 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 4/26/2021 8:50 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			426,338
2.00	Routine service other pass through costs			0
3.00	Ancillary service other pass through costs			0
4.00	Subtotal (sum of lines 1 through 3)			426,338
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0
7.00	Coinsurance			71,390
8.00	Allowable bad debts (see instructions)			0
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
10.00	Adjusted reimbursable bad debts (see instructions)			0
11.00	Utilization review			0
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			354,948
13.00	Inpatient primary payer payments			0
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
14.99	Demonstration payment adjustment amount before sequestration			0
15.00	Subtotal (see instructions)			354,948
15.01	Sequestration adjustment (see instructions)			7,004
15.02	Demonstration payment adjustment amount after sequestration			0
15.75	Sequestration for non-claims based amounts (see instructions)			0
16.00	Interim payments			347,944
17.00	Tentative settlement (for contractor use only)			0
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/26/2021 8:50 am
		Title XIX	Hospital	PPS
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		283,547	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	283,547	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	283,547	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	19,403	844,676	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	19,403	844,676	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	19,403	844,676	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	19,403	561,129	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	283,547	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	283,547	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	283,547	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	283,547	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	283,547	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	283,547	40.00
41.00	Interim payments	0	283,547	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-0167

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

Worksheet G

Date/Time Prepared:
4/26/2021 8:50 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,938,044	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	6,294,334	0	0	0	4.00
5.00	Other receivable	407,777	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,100,041	0	0	0	6.00
7.00	Inventory	853,376	0	0	0	7.00
8.00	Prepaid expenses	321,063	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	192,560	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,907,113	0	0	0	11.00
FIXED ASSETS						
12.00	Land	332,950	0	0	0	12.00
13.00	Land improvements	483,750	0	0	0	13.00
14.00	Accumulated depreciation	-480,377	0	0	0	14.00
15.00	Buildings	26,181,100	0	0	0	15.00
16.00	Accumulated depreciation	-19,221,036	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	16,711,814	0	0	0	19.00
20.00	Accumulated depreciation	-14,840,599	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,167,602	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,436,087	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,436,087	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,510,802	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,420,677	0	0	0	37.00
38.00	Salaries, wages, and fees payable	939,963	0	0	0	38.00
39.00	Payroll taxes payable	-909	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,941,545	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,301,276	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,791,481	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,791,481	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,092,757	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,418,045				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)	5,418,045	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,510,802	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0167

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

Worksheet G-1

Date/Time Prepared:
4/26/2021 8:50 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,491,313		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,073,268				2.00
3.00	Total (sum of line 1 and line 2)		5,418,045		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,418,045		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,418,045		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,620,922		2,620,922	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	4,542,949		4,542,949	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)	7,163,871		7,163,871	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,163,871		7,163,871	17.00
18.00	Ancillary services	0	41,425,694	41,425,694	18.00
19.00	Outpatient services	0	782	782	19.00
20.00	RURAL HEALTH CLINIC	0	591,927	591,927	20.00
20.01	RURAL HEALTH CLINIC II	0	345,583	345,583	20.01
20.02	RURAL HEALTH CLINIC III	0	745,076	745,076	20.02
20.03	RURAL HEALTH CLINIC IV	0	689,381	689,381	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		680,986	680,986	22.00
23.00	AMBULANCE SERVICES	0	1,477	1,477	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,025,751	2,025,751	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)	7,163,871	46,506,657	53,670,528	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,434,297		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,434,297		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0167

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

Worksheet G-3

Date/Time Prepared:
4/26/2021 8:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,670,528	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,424,981	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,245,547	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,434,297	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,188,750	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	139,299	6.00
7.00	Income from investments	518,640	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	98,160	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	97,693	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR GRANT	0	24.00
24.01	340B INCOME/LOSS	906,573	24.01
24.02	MISC NON-PATIENT REVENUE	178,436	24.02
24.03	AMBULANCE SUBSIDY	0	24.03
24.04	OTHER MISC REVENUE	64,726	24.04
24.05	GRANT REVENUE	111,955	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,115,482	25.00
26.00	Total (line 5 plus line 25)	-5,073,268	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,073,268	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0167

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

Worksheet H

HHA CCN: 14-7586

Date/Time Prepared:
4/26/2021 8:50 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	21,043	0	0	21,043	4.00
5.00 Administrative and General	111,902	130	0	25,596	24,587	162,215	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	243,266	282	0	0	0	243,548	6.00
7.00 Physical Therapy	63,249	73	0	0	0	63,322	7.00
8.00 Occupational Therapy	9,731	11	0	0	0	9,742	8.00
9.00 Speech Pathology	973	1	0	0	0	974	9.00
10.00 Medical Social Services	389	0	0	0	0	389	10.00
11.00 Home Health Aide	57,022	66	0	0	0	57,088	11.00
12.00 Supplies (see instructions)	0	0	0	0	12,566	12,566	12.00
13.00 Drugs	0	0	0	0	141	141	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	486,532	563	21,043	25,596	37,294	571,028	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	-13,450	7,593	0	7,593			4.00
5.00 Administrative and General	0	162,215	0	162,215			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	243,548	0	243,548			6.00
7.00 Physical Therapy	0	63,322	0	63,322			7.00
8.00 Occupational Therapy	0	9,742	0	9,742			8.00
9.00 Speech Pathology	0	974	0	974			9.00
10.00 Medical Social Services	0	389	0	389			10.00
11.00 Home Health Aide	0	57,088	0	57,088			11.00
12.00 Supplies (see instructions)	0	12,566	0	12,566			12.00
13.00 Drugs	0	141	0	141			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	-13,450	557,578	0	557,578			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0167

Period:

Worksheet H-1

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)		Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
				Bldgs & Fixtures	Movable Equipment				
				0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	7,593	0	0	0	7,593		4.00	
5.00	Administrative and General	162,215	0	0	0	7,593	169,808	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	243,548	0	0	0	0	243,548	6.00	
7.00	Physical Therapy	63,322	0	0	0	0	63,322	7.00	
8.00	Occupational Therapy	9,742	0	0	0	0	9,742	8.00	
9.00	Speech Pathology	974	0	0	0	0	974	9.00	
10.00	Medical Social Services	389	0	0	0	0	389	10.00	
11.00	Home Health Aide	57,088	0	0	0	0	57,088	11.00	
12.00	Supplies (see instructions)	12,566	0	0	0	0	12,566	12.00	
13.00	Drugs	141	0	0	0	0	141	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	557,578	0	0	0	7,593	557,578	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	169,808						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	106,652	350,200					6.00	
7.00	Physical Therapy	27,729	91,051					7.00	
8.00	Occupational Therapy	4,266	14,008					8.00	
9.00	Speech Pathology	427	1,401					9.00	
10.00	Medical Social Services	170	559					10.00	
11.00	Home Health Aide	24,999	82,087					11.00	
12.00	Supplies (see instructions)	5,503	18,069					12.00	
13.00	Drugs	62	203					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		557,578					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-1

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/26/2021 8:50 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,350			0		1.00
2.00	Capital Related - Movable Equipment		28,165		0		2.00
3.00	Plant Operation & Maintenance	0	0	2,350	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	2,350	28,165	2,350	100	-169,808	387,770
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	243,548	6.00
7.00	Physical Therapy	0	0	0	0	63,322	7.00
8.00	Occupational Therapy	0	0	0	0	9,742	8.00
9.00	Speech Pathology	0	0	0	0	974	9.00
10.00	Medical Social Services	0	0	0	0	389	10.00
11.00	Home Health Aide	0	0	0	0	57,088	11.00
12.00	Supplies (see instructions)	0	0	0	0	12,566	12.00
13.00	Drugs	0	0	0	0	141	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,350	28,165	2,350	100	-169,808	387,770
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	7,593		169,808
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	75.930000		0.437909

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:
4/26/2021 8:50 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	16,187	14,657	16,185	3,568	840	1.00
2.00	Skilled Nursing Care	350,200	0	0	35,185	0	0	2.00
3.00	Physical Therapy	91,051	0	0	9,148	0	0	3.00
4.00	Occupational Therapy	14,008	0	0	1,408	0	0	4.00
5.00	Speech Pathology	1,401	0	0	141	0	0	5.00
6.00	Medical Social Services	559	0	0	56	0	0	6.00
7.00	Home Health Aide	82,087	0	0	8,248	0	0	7.00
8.00	Supplies (see instructions)	18,069	0	0	0	0	0	8.00
9.00	Drugs	203	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	557,578	16,187	14,657	70,371	3,568	840	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	5A.05	5.06	7.00	
1.00	Administrative and General	21,646	0	6,653	79,736	7,642	31,166	1.00
2.00	Skilled Nursing Care	0	0	0	385,385	36,937	0	2.00
3.00	Physical Therapy	0	0	0	100,199	9,604	0	3.00
4.00	Occupational Therapy	0	0	0	15,416	1,478	0	4.00
5.00	Speech Pathology	0	0	0	1,542	148	0	5.00
6.00	Medical Social Services	0	0	0	615	59	0	6.00
7.00	Home Health Aide	0	0	0	90,335	8,658	0	7.00
8.00	Supplies (see instructions)	0	0	0	18,069	1,732	0	8.00
9.00	Drugs	0	0	0	203	19	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	21,646	0	6,653	691,500	66,277	31,166	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 amHome Health
Agency I

PPS

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	10,862	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	1,156	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	10,862	0	0	0	1,156	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	4,631	134,037	0	134,037			1.00
2.00	Skilled Nursing Care	0	422,322	0	422,322	84,292	506,614	2.00
3.00	Physical Therapy	0	109,803	0	109,803	21,916	131,719	3.00
4.00	Occupational Therapy	0	16,894	0	16,894	3,372	20,266	4.00
5.00	Speech Pathology	0	1,690	0	1,690	337	2,027	5.00
6.00	Medical Social Services	0	674	0	674	135	809	6.00
7.00	Home Health Aide	0	98,993	0	98,993	19,758	118,751	7.00
8.00	Supplies (see instructions)	0	20,957	0	20,957	4,183	25,140	8.00
9.00	Drugs	0	222	0	222	44	266	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,631	805,592	0	805,592	134,037	805,592	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.199592		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/26/2021 8:50 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	DATA PROCESSING (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	2,350	28,165	110,208	680,986	12,566	15,468	1.00
2.00	Skilled Nursing Care	0	0	239,582	0	0	0	2.00
3.00	Physical Therapy	0	0	62,291	0	0	0	3.00
4.00	Occupational Therapy	0	0	9,584	0	0	0	4.00
5.00	Speech Pathology	0	0	958	0	0	0	5.00
6.00	Medical Social Services	0	0	383	0	0	0	6.00
7.00	Home Health Aide	0	0	56,159	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,350	28,165	479,165	680,986	12,566	15,468	20.00
21.00	Total cost to be allocated	16,187	14,657	70,371	3,568	840	21,646	21.00
22.00	Unit cost multiplier	6.888085	0.520398	0.146862	0.005239	0.066847	1.399405	22.00
Cost Center Description		COMMUNICATIONS	BUSINESS OFFICE	Reconciliation	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		(# OF PHONES)	(GROSS CHARGES)		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	
		5.04	5.05	5A.06	5.06	7.00	8.00	
1.00	Administrative and General	0	680,986	0	79,736	2,350	0	1.00
2.00	Skilled Nursing Care	0	0	0	385,385	0	0	2.00
3.00	Physical Therapy	0	0	0	100,199	0	0	3.00
4.00	Occupational Therapy	0	0	0	15,416	0	0	4.00
5.00	Speech Pathology	0	0	0	1,542	0	0	5.00
6.00	Medical Social Services	0	0	0	615	0	0	6.00
7.00	Home Health Aide	0	0	0	90,335	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	18,069	0	0	8.00
9.00	Drugs	0	0	0	203	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	680,986		691,500	2,350	0	20.00
21.00	Total cost to be allocated	0	6,653		66,277	31,166	0	21.00
22.00	Unit cost multiplier	0.000000	0.009770		0.095845	13.262128	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/26/2021 8:50 amHome Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	2,350	0	0	0	0	680,986	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	12,566	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,350	0	0	0	12,566	680,986	20.00
21.00	Total cost to be allocated	10,862	0	0	0	1,156	4,631	21.00
22.00	Unit cost multiplier	4.622128	0.000000	0.000000	0.000000	0.091994	0.006800	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

4/26/2021 8:50 am

				Title XVIII		Home Health Agency I	PPS			
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)			
		0	1.00	2.00	3.00	4.00	5.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	2.00	506,614		506,614	2,161	234.43	1.00		
2.00	Physical Therapy	3.00	131,719	0	131,719	971	135.65	2.00		
3.00	Occupational Therapy	4.00	20,266	0	20,266	413	49.07	3.00		
4.00	Speech Pathology	5.00	2,027	0	2,027	32	63.34	4.00		
5.00	Medical Social Services	6.00	809		809	12	67.42	5.00		
6.00	Home Health Aide	7.00	118,751		118,751	346	343.21	6.00		
7.00	Total (sum of lines 1-6)		780,186	0	780,186	3,935		7.00		
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits					
					Part B					
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00			
Limitation Cost Computation										
8.00	Skilled Nursing Care		16580	0	82			8.00		
8.01	Skilled Nursing Care		19180	0	208			8.01		
8.02	Skilled Nursing Care		99914	0	1,223			8.02		
9.00	Physical Therapy		16580	0	30			9.00		
9.01	Physical Therapy		19180	0	7			9.01		
9.02	Physical Therapy		99914	0	770			9.02		
10.00	Occupational Therapy		16580	0	10			10.00		
10.01	Occupational Therapy		19180	0	3			10.01		
10.02	Occupational Therapy		99914	0	217			10.02		
11.00	Speech Pathology		16580	0	0			11.00		
11.01	Speech Pathology		19180	0	0			11.01		
11.02	Speech Pathology		99914	0	17			11.02		
12.00	Medical Social Services		16580	0	0			12.00		
12.01	Medical Social Services		19180	0	0			12.01		
12.02	Medical Social Services		99914	0	6			12.02		
13.00	Home Health Aide		16580	0	0			13.00		
13.01	Home Health Aide		19180	0	0			13.01		
13.02	Home Health Aide		99914	0	199			13.02		
14.00	Total (sum of lines 8-13)			0	2,772			14.00		
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)			
		0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations										
15.00	Cost of Medical Supplies	8.00	25,140	0	25,140	13,793	1.822664	15.00		
16.00	Cost of Drugs	9.00	266	0	266	0	0.000000	16.00		
Cost Center Description		Program Visits			Cost of Services					
		Part A	Part B		Part A	Part B	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance					Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	0	1,513		0	354,693		1.00		
2.00	Physical Therapy	0	807		0	109,470		2.00		
3.00	Occupational Therapy	0	230		0	11,286		3.00		
4.00	Speech Pathology	0	17		0	1,077		4.00		
5.00	Medical Social Services	0	6		0	405		5.00		
6.00	Home Health Aide	0	199		0	68,299		6.00		
7.00	Total (sum of lines 1-6)	0	2,772		0	545,230		7.00		

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
8.02	Skilled Nursing Care								8.02
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
9.02	Physical Therapy								9.02
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
10.02	Occupational Therapy								10.02
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
11.02	Speech Pathology								11.02
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
12.02	Medical Social Services								12.02
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
13.02	Home Health Aide								13.02
14.00	Total (sum of lines 8-13)								14.00
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00	10.00	11.00
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	3,123	0	0	5,692		15.00
16.00	Cost of Drugs		0	0		0	0		16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
		Cost Per Visit Computation							
1.00	Skilled Nursing Care	354,693							1.00
2.00	Physical Therapy	109,470							2.00
3.00	Occupational Therapy	11,286							3.00
4.00	Speech Pathology	1,077							4.00
5.00	Medical Social Services	405							5.00
6.00	Home Health Aide	68,299							6.00
7.00	Total (sum of lines 1-6)	545,230							7.00
Cost Center Description									
		12.00							
	Limitation Cost Computation								
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
8.02	Skilled Nursing Care								8.02
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
9.02	Physical Therapy								9.02
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
10.02	Occupational Therapy								10.02
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
11.02	Speech Pathology								11.02
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
12.02	Medical Social Services	12.02							
13.00	Home Health Aide	13.00							
13.01	Home Health Aide	13.01							
13.02	Home Health Aide	13.02							
14.00	Total (sum of lines 8-13)	14.00							

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/26/2021 8:50 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.578929	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.291064	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.491772	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167 HHA CCN: 14-7586	Period: From 10/01/2019 To 09/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 4/26/2021 8:50 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	426,204
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	32,298
13.00	Total PPS Reimbursement - LUPA Episodes		0	6,469
14.00	Total PPS Reimbursement - PEP Episodes		0	1,708
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	9,525
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	476,204
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	476,204
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	476,204
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	476,204
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	476,204
31.01	Sequestration adjustment (see instructions)		0	5,070
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	471,134
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-0167

Period:

Worksheet H-5

HHA CCN: 14-7586

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/26/2021 8:50 am

Home Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		471,134	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		471,134	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		471,134	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

				Hospice I		7/20/2022 5:00 am	
		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	7,021	7,021	0	7,021	3.00
4.00	ADMINISTRATIVE & GENERAL*	184,884	59,833	244,717	0	244,717	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	15,649	15,649	0	15,649	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	22	22	0	22	8.00
9.00	NURSING ADMINISTRATION*	62,630	0	62,630	0	62,630	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	12,420	12,420	-4,827	7,593	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	91,967	91,967	0	91,967	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	16,877	16,877	0	16,877	26.00
27.00	NURSE PRACTITIONER**	5,169	0	5,169	0	5,169	27.00
28.00	REGISTERED NURSE**	303,355	0	303,355	0	303,355	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**	107,176	0	107,176	0	107,176	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	11,485	11,485	0	11,485	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	101,392	101,392	0	101,392	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
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	663,214	316,666	979,880	-4,827	975,053	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: 14-0167

Period:

Worksheet 0

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	7,021	3.00
4.00	ADMINISTRATIVE & GENERAL*	-317	244,400	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	15,649	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	22	8.00
9.00	NURSING ADMINISTRATION*	0	62,630	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	7,593	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	91,967	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	16,877	26.00
27.00	NURSE PRACTITIONER**	0	5,169	27.00
28.00	REGISTERED NURSE**	0	303,355	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	107,176	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	11,485	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	101,392	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-317	974,736	100.00

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

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

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

Provider CCN: 14-0167

Period:

Worksheet 0-2

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

				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	16,800	16,800	0	16,800	26.00
27.00	NURSE PRACTITIONER	5,145	0	5,145	0	5,145	27.00
28.00	REGISTERED NURSE	301,956	0	301,956	0	301,956	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	106,682	0	106,682	0	106,682	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	11,432	11,432	0	11,432	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	100,924	100,924	0	100,924	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 *	413,783	129,156	542,939	0	542,939	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	16,800	26.00
27.00	NURSE PRACTITIONER	0	5,145	27.00
28.00	REGISTERED NURSE	0	301,956	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	106,682	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	11,432	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	100,924	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	542,939	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CAREProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2019
To 09/30/2020Worksheet 0-3
Date/Time Prepared:
4/26/2021 8:50 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	20	20	0	20	26.00
27.00	NURSE PRACTITIONER	6	0	6	0	6	27.00
28.00	REGISTERED NURSE	368	0	368	0	368	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	130	0	130	0	130	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	14	14	0	14	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	123	123	0	123	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 *	504	157	661	0	661	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	20	26.00
27.00	NURSE PRACTITIONER	0	6	27.00
28.00	REGISTERED NURSE	0	368	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	130	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	14	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	123	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	661	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CAREProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2019
To 09/30/2020Worksheet 0-4
Date/Time Prepared:
4/26/2021 8:50 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	57	57	0	57	26.00
27.00	NURSE PRACTITIONER	18	0	18	0	18	27.00
28.00	REGISTERED NURSE	1,031	0	1,031	0	1,031	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	364	0	364	0	364	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	39	39	0	39	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	345	345	0	345	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,413	441	1,854	0	1,854	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	57	26.00
27.00	NURSE PRACTITIONER	0	18	27.00
28.00	REGISTERED NURSE	0	1,031	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	364	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	39	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	345	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,854	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 ALLOCATIONProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2019
To 09/30/2020Worksheet 0-5
Date/Time Prepared:
4/26/2021 8:50 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,926	14,926	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	7,021	97,400	104,421	3.00
4.00	ADMINISTRATIVE & GENERAL	244,400	193,133	437,533	4.00
5.00	PLANT OPERATION & MAINTENANCE	15,649	0	15,649	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	22	0	22	8.00
9.00	NURSING ADMINISTRATION	62,630	0	62,630	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	6,208	6,208	10.00
11.00	MEDICAL RECORDS	0	13,775	13,775	11.00
12.00	STAFF TRANSPORTATION	7,593	0	7,593	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	91,967	0	91,967	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	542,939	0	542,939	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	661	0	661	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,854	0	1,854	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	974,736	325,442	1,300,178	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 am

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0		1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,926			14,926			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	104,421		0	0	104,421		3.00
4.00	ADMINISTRATIVE & GENERAL	437,533		0	14,926	0	452,459	4.00
5.00	PLANT OPERATION & MAINTENANCE	15,649		0	0	0	15,649	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	22		0	0	0	22	8.00
9.00	NURSING ADMINISTRATION	62,630		0	0	0	62,630	9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,208		0	0	0	6,208	10.00
11.00	MEDICAL RECORDS	13,775		0	0	0	13,775	11.00
12.00	STAFF TRANSPORTATION	7,593		0	0	0	7,593	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	0	0	0	13.00
14.00	PHARMACY	0		0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	91,967		0	0	0	91,967	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	542,939				104,421	647,360	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	661		0	0	0	661	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,854		0	0	0	1,854	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		99.00
100.00	TOTAL	1,300,178		0	14,926	104,421	1,300,178	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 am

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	452,459						4.00
5.00	PLANT OPERATION & MAINTENANCE	8,352	24,001					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	12	0			0	34	8.00
9.00	NURSING ADMINISTRATION	33,428	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,313	0			0		10.00
11.00	MEDICAL RECORDS	7,352	0			0		11.00
12.00	STAFF TRANSPORTATION	4,053	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	49,086	24,001			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	345,520						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	353	0		0	0	9	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	990	0		0	0	25	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	452,459	24,001		0	0	34	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 am

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	96,058				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	9,521			10.00
11.00	MEDICAL RECORDS	0		21,127		11.00
12.00	STAFF TRANSPORTATION	0			11,646	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	95,615	9,477	21,029	11,530	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	117	12	26	29	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	326	32	72	87	53.00
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					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	96,058	9,521	21,127	11,646	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/26/2021 8:50 am

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		165,054			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	164,293		1,294,824	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	200	0	1,407	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	561	0	3,947	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	165,054	0	1,300,178	100.00

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

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/26/2021 8:50 am

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	2,350					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		15,261				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	663,213			3.00
4.00	ADMINISTRATIVE & GENERAL	0	15,261	0	-452,459	847,719	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	15,649	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	22	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	62,630	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	6,208	10.00
11.00	MEDICAL RECORDS	0	0	0	0	13,775	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	7,593	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	2,350	0	0	0	91,967	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			663,213	0	647,360	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	661	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	1,854	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	14,926	104,421		452,459	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.978049	0.157447		0.533737	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASISProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2019
To 09/30/2020Worksheet 0-6
Part II
Date/Time Prepared:
4/26/2021 8:50 am

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	2,350					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		2,350			7.00
8.00	DIETARY	0		0	57		8.00
9.00	NURSING ADMINISTRATION	0		0		12,357	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	2,350		2,350		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					12,300	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	15	15	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	42	42	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)	24,001	0	0	34	96,058	100.00
101.00	UNIT COST MULTIPLIER	10.213191	0.000000	0.000000	0.596491	7.773570	101.00

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

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

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

Worksheet 0-6
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	12,357				10.00
11.00	MEDICAL RECORDS		12,357			11.00
12.00	STAFF TRANSPORTATION			33,692		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0	0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	12,300	12,300	33,356	0	0 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	15	15	84	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	42	42	252	0	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	9,521	21,127	11,646	0	0 100.00
101.00	UNIT COST MULTIPLIER	0.770494	1.709719	0.345661	0.000000	0.000000 101.00

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

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

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

Worksheet 0-6
Part II
Date/Time Prepared:
4/26/2021 8:50 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		12,357			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	12,300			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	15	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	42	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	165,054	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	13.357126	0.000000		101.00

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

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

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

Worksheet 0-7
Date/Time Prepared:
4/26/2021 8:50 am

					Hospice I		
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.578929	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.491772	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.255535	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.291064	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0167

Period:

Worksheet 0-8

Hospice CCN: 14-1616

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		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)			1,294,824	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			12,300	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			105.27	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	11,362	33		9.00
10.00	Program cost (line 8 times line 9)	1,196,078	3,474		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)			1,407	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			15	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			93.80	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	15	0		14.00
15.00	Program cost (line 13 times line 14)	1,407	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)			3,947	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			42	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			93.98	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	29	0		19.00
20.00	Program cost (line 18 times line 19)	2,725	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,300,178	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			12,357	22.00
23.00	Average cost per diem (line 21 divided by line 22)			105.22	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 4/26/2021 8:50 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		125,522	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,637	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		2.58	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)		127,159	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3424

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/26/2021 8:50 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	246,410	0	246,410	-578	245,832
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	138,580	0	138,580	-159	138,421
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	49,126	0	49,126	0	49,126
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	434,116	0	434,116	-737	433,379
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	14,881	14,881	0	14,881
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	14,881	14,881	0	14,881
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	434,116	14,881	448,997	-737	448,260
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	737	737
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	737	737
FACILITY OVERHEAD						
29.00	Facility Costs	0	25,471	25,471	0	25,471
30.00	Administrative Costs	49,549	75,113	124,662	0	124,662
31.00	Total Facility Overhead (sum of lines 29 and 30)	49,549	100,584	150,133	0	150,133
32.00	Total facility costs (sum of lines 22, 28 and 31)	483,665	115,465	599,130	0	599,130

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3424

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	113,494	359,326	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	138,421	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	49,126	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	113,494	546,873	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	14,881	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,881	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	113,494	561,754	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	737	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	737	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	25,471	29.00
30.00	Administrative Costs	-33,945	90,717	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-33,945	116,188	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	79,549	678,679	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3425

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	87,703	0	87,703	-570	87,133
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	179,343	0	179,343	-2,217	177,126
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	267,046	0	267,046	-2,787	264,259
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	10,355	10,355	0	10,355
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	10,355	10,355	0	10,355
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	267,046	10,355	277,401	-2,787	274,614
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	2,787	2,787
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	2,787	2,787
FACILITY OVERHEAD						
29.00	Facility Costs	0	18,570	18,570	0	18,570
30.00	Administrative Costs	40,382	71,334	111,716	0	111,716
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,382	89,904	130,286	0	130,286
32.00	Total facility costs (sum of lines 22, 28 and 31)	307,428	100,259	407,687	0	407,687

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3425

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	87,133		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-111,944	65,182		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-111,944	152,315		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	10,355		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,355		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-111,944	162,670		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	2,787		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,787		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	18,570		29.00
30.00	Administrative Costs	-34,544	77,172		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-34,544	95,742		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-146,488	261,199		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 15-3979

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	352,019	0	352,019	-781	351,238
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	236,114	0	236,114	-2,123	233,991
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	588,133	0	588,133	-2,904	585,229
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	27,085	27,085	0	27,085
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	27,085	27,085	0	27,085
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	588,133	27,085	615,218	-2,904	612,314
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	2,904	2,904
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	2,904	2,904
FACILITY OVERHEAD						
29.00	Facility Costs	0	40,148	40,148	0	40,148
30.00	Administrative Costs	160,041	134,295	294,336	0	294,336
31.00	Total Facility Overhead (sum of lines 29 and 30)	160,041	174,443	334,484	0	334,484
32.00	Total facility costs (sum of lines 22, 28 and 31)	748,174	201,528	949,702	0	949,702

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 15-3979

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	351,238	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-1,550	232,441	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-1,550	583,679	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	27,085	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	27,085	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,550	610,764	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	2,904	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,904	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	40,148	29.00
30.00	Administrative Costs	-41,365	252,971	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-41,365	293,119	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,915	906,787	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-8551

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	813,049	0	813,049	-24,296	788,753	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	120,215	0	120,215	-3,430	116,785	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	93,611	0	93,611	0	93,611	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,026,875	0	1,026,875	-27,726	999,149	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	19,524	19,524	0	19,524	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,524	19,524	0	19,524	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,026,875	19,524	1,046,399	-27,726	1,018,673	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	27,726	27,726	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	27,726	27,726	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	2,289	2,289	0	2,289	29.00
30.00	Administrative Costs	79,136	1,083,567	1,162,703	0	1,162,703	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	79,136	1,085,856	1,164,992	0	1,164,992	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,106,011	1,105,380	2,211,391	0	2,211,391	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-8551

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-113,638	675,115	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	116,785	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	93,611	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-113,638	885,511	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	19,524	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,524	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-113,638	905,035	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	27,726	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	27,726	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	2,289	29.00
30.00	Administrative Costs	-178,651	984,052	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-178,651	986,341	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-292,289	1,919,102	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-3424

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

Date/Time Prepared:

4/26/2021 8:50 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.88	2,126	4,200	3,696	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.70	1,740	2,100	1,470	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.58	3,866		5,166	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.58	3,866		5,166	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				561,754	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				737	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				562,491	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998690	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				116,188	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				293,229	15.00
16.00	Total overhead (sum of lines 14 and 15)				409,417	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				409,417	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				408,881	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				970,635	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-3425

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/26/2021 8:50 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.35	1,071	4,200	1,470		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.91	1,358	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.26	2,429		3,381	3,381	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.26	2,429			3,381	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					162,670	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,787	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					165,457	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.983156	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					95,742	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					167,680	15.00
16.00	Total overhead (sum of lines 14 and 15)					263,422	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					263,422	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					258,985	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					421,655	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 15-3979

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

Date/Time Prepared:

4/26/2021 8:50 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.15	1,798	4,200	4,830		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.38	2,535	2,100	2,898		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.53	4,333		7,728	7,728	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.53	4,333			7,728	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					610,764	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,904	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					613,668	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995268	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					293,119	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					368,057	15.00
16.00	Total overhead (sum of lines 14 and 15)					661,176	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					661,176	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					658,047	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,268,811	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-8551

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

Date/Time Prepared:

4/26/2021 8:50 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.17	10,023	4,200	9,114		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.92	4,155	2,100	1,932		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.09	14,178		11,046	14,178	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.09	14,178			14,178	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					905,035	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					27,726	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					932,761	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.970275	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					986,341	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					531,239	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,517,580	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,517,580	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,472,470	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,377,505	20.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 14-3424		Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			970,635	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			22,210	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			948,425	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,166	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,166	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			183.59	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		183.59	183.59	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		404	1,222	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		74,170	224,347	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	298,517	16.00
16.01	Total program charges (see instructions)(from contractor's records)			210,357	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			10,389	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			14,743	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			204,518	16.04
16.05	Total program cost (see instructions)		0	219,261	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			28,127	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			34,145	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			219,261	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			12,415	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			231,676	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			231,676	26.00
26.01	Sequestration adjustment (see instructions)			2,687	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			162,640	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			66,349	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 14-3425		Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC II	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			421,655	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			25,311	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			396,344	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,381	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,381	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			117.23	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		117.23	117.23	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		250	661	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		29,308	77,489	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	106,797	16.00
16.01	Total program charges (see instructions)(from contractor's records)			109,749	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			8,949	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			8,708	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			63,605	16.04
16.05	Total program cost (see instructions)		0	72,313	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			18,583	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			16,443	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			72,313	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			15,384	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			87,697	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			87,697	26.00
26.01	Sequestration adjustment (see instructions)			1,017	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			107,147	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			-20,467	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/26/2021 8:50 am		
			Title XVIII	RHC III	Cost	
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,268,811	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			28,573	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,240,238	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,728	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			7,728	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			160.49	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			160.49	160.49	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			742	2,062	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			119,084	330,930	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	450,014	16.00
16.01	Total program charges (see instructions)(from contractor's records)				391,843	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				5,707	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				6,554	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				315,180	16.04
16.05	Total program cost (see instructions)			0	321,734	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				49,485	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				67,218	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				321,734	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				14,772	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				336,506	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				336,506	26.00
26.01	Sequestration adjustment (see instructions)				3,903	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				375,818	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				-43,215	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC IV	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,377,505	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			46,218	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,331,287	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,178	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			14,178	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			164.43	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		164.43	164.43	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		436	8,827	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		71,691	1,451,424	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,523,115	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,471,927	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			13,363	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			13,828	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,186,354	16.04
16.05	Total program cost (see instructions)		0	1,200,182	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			26,344	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			285,606	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,200,182	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			27,308	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,227,490	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,227,490	26.00
26.01	Sequestration adjustment (see instructions)			14,239	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,240,799	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			-27,548	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 14-3424	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		546,873	546,873	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001014	0.006492	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		555	3,550	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,055	5,694	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,610	9,244	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		561,754	561,754	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		408,881	408,881	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006426	0.016456	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,627	6,729	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		6,237	15,973	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		20	128	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		311.85	124.79	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		15	62	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,678	7,737	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			22,210	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			12,415	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 14-3425	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		152,315	152,315	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001017	0.008521	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		155	1,298	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,590	5,722	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,745	7,020	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		162,670	162,670	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		258,985	258,985	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.016875	0.043155	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,370	11,176	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		7,115	18,196	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		16	134	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		444.69	135.79	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		12	74	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		5,336	10,048	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			25,311	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			15,384	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		583,679	583,679	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000697	0.005068	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		407	2,958	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,516	6,873	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,923	9,831	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		610,764	610,764	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		658,047	658,047	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006423	0.016096	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,227	10,592	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		8,150	20,423	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		22	160	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		370.45	127.64	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		13	78	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,816	9,956	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			28,573	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			14,772	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/26/2021 8:50 am	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		885,511	885,511	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001193	0.003916	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,056	3,468	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,396	6,674	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		7,452	10,142	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		905,035	905,035	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,472,470	1,472,470	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008234	0.011206	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		12,124	16,500	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		19,576	26,642	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		46	151	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		425.57	176.44	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		31	80	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		13,193	14,115	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			46,218	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			27,308	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-3424	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/26/2021 8:50 am
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		162,640	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		162,640	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		66,349	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		228,989	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-3425	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/26/2021 8:50 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		107,147	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		107,147	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		20,467	6.02
7.00	Total Medicare program liability (see instructions)		86,680	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/26/2021 8:50 am
		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		375,818	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		375,818	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		43,215	6.02
7.00	Total Medicare program liability (see instructions)		332,603	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/26/2021 8:50 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1,240,799	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			1,240,799	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			27,548	6.02
7.00	Total Medicare program liability (see instructions)			1,213,251	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00