

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 2:09 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.		Date: 2/28/2022 Time: 2:09 pm
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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Timothy Moore	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Timothy Moore		2
3	Signatory Title	VP-FINANCE, CAO		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-667,655	-69,675	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	149,228	-379		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	30,704	-20,861		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		21,639		0	10.00
200.00 Total	0	-487,723	-69,276	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 2:09 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1005 BROADWAY			PO Box:				1.00		
2.00	City: QUINCY			State: IL		Zip Code: 62301		County: ADAMS		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF		BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984			
15.00	Hospital-Based Health Clinic - RHC		GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2020	09/30/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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		22.04
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: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,349	3,856	0	2,891	8,145	123	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.	28	96	0	40	132		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.					10/01/2020	09/30/2021	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
	Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
	Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 2:09 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1		60.01	
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1		60.02	
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1		60.03	
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.03	1		60.04	
60.05	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.04	1		60.05	
60.06	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.05	1		60.06	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	
61.01	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 2:09 pm		
			1.00			
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		Y			75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	76.00	
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00	
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N		91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N		93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N		94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y		98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y		98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y		98.02	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 2:09 pm
		V 1.00	XIX 2.00	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
				Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00
				1.00
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
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		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	144,031	2,833,372	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 2:09 pm	
		1.00		2.00			
118.00	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.00	
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		14H132		140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131		141.00	
142.00	Street: BROADWAY AT 11TH STREET	PO Box:				142.00	
143.00	City: QUINCY	State: IL		Zip Code: 62301		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 2:09 pm	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						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		0171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 2:09 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2021	Y 12/31/2021
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: 14-0015

Period:
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Part II
Date/Time Prepared:
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALT H.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	264	96,360	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		264	96,360	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	9,125	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		289	105,485	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		327				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,325	1,178	57,739			1.00
2.00	HMO and other (see instructions)	7,159	14,892				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	504	268				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)	26,325	1,178	57,739			7.00
8.00	INTENSIVE CARE UNIT	2,940	135	6,583			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		36	1,737			13.00
14.00	Total (see instructions)	29,265	1,349	66,059	16.76	2,271.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	3,067	28	4,772	0.31	25.86	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,972	296	4,428	0.00	27.06	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	20,860	0	42,520	0.00	43.81	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	25.33	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,460	0	5,288	0.00	8.55	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.07	2,402.46	27.00
28.00	Observation Bed Days		0	6,466			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1,213			30.00
31.00	Employee discount days - IRF			57			31.00
32.00	Labor & delivery days (see instructions)	0	123	460			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,448	201	13,052	1.00
2.00 HMO and other (see instructions)			1,290	3,255		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				22		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5,448	201	13,052	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	186	3	290	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	161,187,063	0	161,187,063	4,762,166.83	33.85
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		206,950	0	206,950	1,116.00	185.44
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		15,861,270	0	15,861,270	87,739.44	180.78
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		520,153	0	520,153	17,540.00	29.66
7.00	Interns & residents (in an approved program)	21.00	1,101,295	0	1,101,295	37,422.96	29.43
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	1,519,759	-23,912	1,495,847	55,576.72	26.91
10.00	Excluded area salaries (see instructions)		13,272,882	684,177	13,957,059	379,468.62	36.78
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,062,253	0	6,062,253	51,321.00	118.12
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		637,879	0	637,879	3,980.00	160.27
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		6,098,190	0	6,098,190	75,473.80	80.80
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)		44,526,314	0	44,526,314		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		4,865,306	0	4,865,306		
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		30,910	0	30,910		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		2,381,173	0	2,381,173		
24.00	Wage-related costs (RHC/FQHC)		184,816	0	184,816		
25.00	Interns & residents (in an approved program)		393,445	0	393,445		
25.50	Home office wage-related (core)		1,424,989	0	1,424,989		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	3,645,364	0	3,645,364	210,067.65	17.35	26.00
27.00	Administrative & General	5.00	27,481,606	-15,347	27,466,259	893,404.88	30.74	27.00
28.00	Administrative & General under contract (see inst.)		1,190,620	0	1,190,620	4,218.91	282.21	28.00
29.00	Maintenance & Repairs	6.00	3,679,200	0	3,679,200	152,883.82	24.07	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	43,123	0	43,123	2,436.16	17.70	31.00
32.00	Housekeeping	9.00	3,213,659	0	3,213,659	193,247.07	16.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,009,491	-1,809,606	1,199,885	72,906.05	16.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,809,606	1,809,606	109,953.38	16.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	8,732,925	-87,969	8,644,956	246,737.09	35.04	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	4,098,898	0	4,098,898	172,241.96	23.80	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/28/2022 2:09 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	144,894,965	0	144,894,965	4,623,683.34	31.34	1.00
2.00	Excluded area salaries (see instructions)	14,792,641	660,265	15,452,906	435,045.34	35.52	2.00
3.00	Subtotal salaries (line 1 minus line 2)	130,102,324	-660,265	129,442,059	4,188,638.00	30.90	3.00
4.00	Subtotal other wages & related costs (see inst.)	12,798,322	0	12,798,322	130,774.80	97.87	4.00
5.00	Subtotal wage-related costs (see inst.)	45,982,213	0	45,982,213	0.00	35.52	5.00
6.00	Total (sum of lines 3 thru 5)	188,882,859	-660,265	188,222,594	4,319,412.80	43.58	6.00
7.00	Total overhead cost (see instructions)	55,094,886	-103,316	54,991,570	2,058,096.97	26.72	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
2/28/2022 2:09 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	5,564,226	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)	655,279	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	33,444,059	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	146,643	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)	297,455	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	173,709	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	10,970,855	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	69,788	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,059,950	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	52,381,964	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	6,220,154	52,381,964	1.00
2.00	Hospital	6,062,253	44,526,315	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	18,644	541,799	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	139,257	470,963	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	1,034,555	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	609,488	13.00
14.00	Hospital-Based Health Clinic RHC	0	184,816	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	5,014,028	18.00

Health Financial Systems		BLESSING HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet S-4	
				Component CCN: 14-7031		Date/Time Prepared: 2/28/2022 2:09 pm	
					Home Health Agency I	PPS	
				1.00			
0.00	County				ADAMS	0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	7,906	0	5,049	12,955	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	887.00	0.00	1,152.00	2,039.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			9.66	0.00	9.66	5.00
6.00	Direct Nursing Service			14.13	0.00	14.13	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			9.68	0.00	9.68	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.69	0.00	1.69	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.39	0.00	0.39	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.03	0.00	1.03	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			6.23	0.00	6.23	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					2	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99914	20.00
20.01						99926	20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	9,266	323	200	47	9,836	21.00
22.00	Skilled Nursing Visit Charges	1,575,220	54,910	34,000	7,990	1,672,120	22.00
23.00	Physical Therapy Visits	5,798	334	72	47	6,251	23.00
24.00	Physical Therapy Visit Charges	982,940	56,780	12,240	7,990	1,059,950	24.00
25.00	Occupational Therapy Visits	1,453	279	21	20	1,773	25.00
26.00	Occupational Therapy Visit Charges	246,500	47,430	3,570	3,400	300,900	26.00
27.00	Speech Pathology Visits	106	47	3	1	157	27.00
28.00	Speech Pathology Visit Charges	18,020	7,990	510	170	26,690	28.00
29.00	Medical Social Service Visits	11	2	0	0	13	29.00
30.00	Medical Social Service Visit Charges	1,870	340	0	0	2,210	30.00
31.00	Home Health Aide Visits	2,445	370	0	15	2,830	31.00
32.00	Home Health Aide Visit Charges	229,830	34,780	0	1,410	266,020	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	19,079	1,355	296	130	20,860	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,054,380	202,230	50,320	20,960	3,327,890	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,996		172	19	2,187	36.00
37.00	Total Number of Outlier Episodes		46		0	46	37.00
38.00	Total Non-Routine Medical Supply Charges	94,105	3,079	4,674	124	101,982	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-0015
 Component CCN: 14-3422

 Period:
 From 10/01/2020
 To 09/30/2021

Worksheet S-8

 Date/Time Prepared:
 2/28/2022 2:09 pm

				RHC I		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			102 PRAIRIE MILLS ROAD			1.00
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			GOLDEN IL 62339		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0	10.00
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			08:00		17:00	08:00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
			Y/N	V	XVIII	XIX	Total Visits
			1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
			County				
			4.00				
2.00	City, State, ZIP Code, County			ADAMS		2.00	
			Tuesday		Wednesday		Thursday
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00	08:00	17:00	08:00
				17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0015

Period:

Worksheet S-8

Component CCN: 14-3422

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

RHC I

Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0015

Period:

Worksheet S-9

Hospice CCN: 14-1501

From 10/01/2020
To 09/30/2021PARTS I THROUGH IV
Date/Time Prepared:
2/28/2022 2:09 pm

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	18,488	971	808	20,267	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	471	21	18	510	13.00
14.00	Total Hospice Days	18,959	992	826	20,777	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	471	21	18	510	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/28/2022 2:09 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.177186 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	10,070,942		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	23,229,267		5.00
6.00	Medicaid charges	291,244,533		6.00
7.00	Medicaid cost (line 1 times line 6)	51,604,454		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)	18,304,245		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)	18,304,245		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)	23,461,399	2,705,538	26,166,937 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,157,031	2,705,538	6,862,569 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)	4,157,031	2,705,538	6,862,569 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)	11,621,862		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,364,505		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,099,240		27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,522,622		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,422,010		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,284,579		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	27,588,824		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		660	660	38,039	38,699	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES		8,161,417	8,161,417	56,525	8,217,942	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES		1,789,235	1,789,235	2,693,017	4,482,252	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I		0	0	73,179	73,179	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL		0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST		0	0	0	0	1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER		0	0	0	0	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,680,388	13,680,388	81,766	13,762,154	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,645,364	53,427,200	57,072,564	0	57,072,564	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,481,606	155,070,360	182,551,966	-402,850	182,149,116	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,679,200	7,751,925	11,431,125	0	11,431,125	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,123	1,724,588	1,767,711	0	1,767,711	8.00
9.00	00900	HOUSEKEEPING	3,213,659	1,556,491	4,770,150	296,620	5,066,770	9.00
10.00	01000	DIETARY	3,009,491	4,317,127	7,326,618	-4,405,494	2,921,124	10.00
11.00	01100	CAFETERIA	0	0	0	4,405,494	4,405,494	11.00
13.00	01300	NURSING ADMINISTRATION	8,732,925	931,219	9,664,144	-87,989	9,576,155	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,098,898	1,080,223	5,179,121	0	5,179,121	16.00
20.00	02000	NURSING PROGRAM	4,364,790	3,701,214	8,066,004	-1,806,260	6,259,744	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,101,295	0	1,101,295	0	1,101,295	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,127,070	2,127,070	0	2,127,070	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	240,442	5,571	246,013	31,944	277,957	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	199,154	199,154	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	358,663	4,947	363,610	0	363,610	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	271,477	271,477	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	339,557	339,557	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,657,087	9,828,389	39,485,476	1,381,231	40,866,707	30.00
31.00	03100	INTENSIVE CARE UNIT	6,412,654	1,233,305	7,645,959	-412,236	7,233,723	31.00
41.00	04100	SUBPROVIDER - IRF	1,734,812	159,866	1,894,678	-17,215	1,877,463	41.00
43.00	04300	NURSERY	321,733	55,101	376,834	-65,265	311,569	43.00
44.00	04400	SKILLED NURSING FACILITY	1,519,759	277,649	1,797,408	-31,195	1,766,213	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,937,020	30,748,221	42,685,241	-23,809,393	18,875,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	701,799	247,439	949,238	-140,170	809,068	52.00
53.00	05300	ANESTHESIOLOGY	197,466	840,191	1,037,657	-357,543	680,114	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,194,690	2,072,262	7,266,952	-243,197	7,023,755	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	909,462	532,592	1,442,054	-5,278	1,436,776	55.00
57.00	05700	CT SCAN	638,506	264,101	902,607	-73,555	829,052	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	292,363	264,219	556,582	-1,568	555,014	58.00
60.00	06000	LABORATORY	3,146,700	8,056,755	11,203,455	-74,771	11,128,684	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,781	1,069,808	1,205,589	0	1,205,589	62.00
65.00	06500	RESPIRATORY THERAPY	2,719,839	943,231	3,663,070	-514,390	3,148,680	65.00
66.00	06600	PHYSICAL THERAPY	1,522,810	17,504	1,540,314	5,575	1,545,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	884,992	-3,548	881,444	-70	881,374	67.00
68.00	06800	SPEECH PATHOLOGY	269,266	2,386	271,652	-696	270,956	68.00
69.00	06900	ELECTROCARDIOLOGY	2,431,234	9,852,416	12,283,650	-8,986,259	3,297,391	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	547,196	125,359	672,555	-5,304	667,251	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,040,198	1,386,180	2,426,378	13,402,921	15,829,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,255,623	21,255,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,081,645	24,220,193	29,301,838	-131	29,301,707	73.00
74.00	07400	RENAL DIALYSIS	0	1,143,660	1,143,660	-18	1,143,642	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	526,719	299,353	826,072	1,437	827,509	88.00
90.00	09000	CLINIC	4,500,183	253,687	4,753,870	-487,975	4,265,895	90.00
90.01	09001	OUTPATIENT INFUSION	424,944	59,996	484,940	-2,317	482,623	90.01
90.02	04950	ONCOLOGY	187,748	37,232	224,980	-2,624	222,356	90.02
91.00	09100	EMERGENCY	11,520,777	2,540,054	14,060,831	-245,541	13,815,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	186,049	6,389	192,438	0	192,438	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,299,478	900,273	4,199,751	-19,948	4,179,803	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		2,841,975	2,841,975	-2,841,975	0	113.00
116.00	11600	HOSPICE	1,920,780	745,006	2,665,786	10,362	2,676,148	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,833,146	356,350,879	516,184,025	-497,306	515,686,719	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,295	3,295	487,469	490,764	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	6,601	6,601	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	1,353,917	7,371,735	8,725,652	3,236	8,728,888	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	161,187,063	363,725,909	524,912,972	0	524,912,972	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	8,810	47,509	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	-7,782,283	435,659	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	3,700,038	8,182,290	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	-61,620	11,559	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	829,315	829,315	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	122,127	122,127	1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	536,846	536,846	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,290,695	18,052,849	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-48,418,736	8,653,828	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-113,402,798	68,746,318	5.00
6.00	00600	MAINTENANCE & REPAIRS	-1,654,424	9,776,701	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-32,102	1,735,609	8.00
9.00	00900	HOUSEKEEPING	-114,599	4,952,171	9.00
10.00	01000	DIETARY	-750,058	2,171,066	10.00
11.00	01100	CAFETERIA	-1,490,093	2,915,401	11.00
13.00	01300	NURSING ADMINISTRATION	1,195,218	10,771,373	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,407,663	6,586,784	16.00
20.00	02000	NURSING PROGRAM	-3,978,207	2,281,537	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,101,295	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,127,070	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-38,300	239,657	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-93,398	105,756	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	363,610	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	-68,544	202,933	23.04
23.05	02305	PARAMED ED PRGM-HIM	-90,719	248,838	23.05
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-6,063,500	34,803,207	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,330,107	5,903,616	31.00
41.00	04100	SUBPROVIDER - IRF	-9,291	1,868,172	41.00
43.00	04300	NURSERY	0	311,569	43.00
44.00	04400	SKILLED NURSING FACILITY	-531	1,765,682	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,560,847	17,315,001	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	809,068	52.00
53.00	05300	ANESTHESIOLOGY	-26,140	653,974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,297,334	5,726,421	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,436,776	55.00
57.00	05700	CT SCAN	0	829,052	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	555,014	58.00
60.00	06000	LABORATORY	414,005	11,542,689	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,205,589	62.00
65.00	06500	RESPIRATORY THERAPY	-10,623	3,138,057	65.00
66.00	06600	PHYSICAL THERAPY	0	1,545,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	881,374	67.00
68.00	06800	SPEECH PATHOLOGY	0	270,956	68.00
69.00	06900	ELECTROCARDIOLOGY	-10,337	3,287,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-68,235	599,016	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,628	15,907,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,255,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-562,618	28,739,089	73.00
74.00	07400	RENAL DIALYSIS	0	1,143,642	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-17,951	809,558	88.00
90.00	09000	CLINIC	-2,685,233	1,580,662	90.00
90.01	09001	OUTPATIENT INFUSION	0	482,623	90.01
90.02	04950	ONCOLOGY	0	222,356	90.02
91.00	09100	EMERGENCY	-6,801,450	7,013,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	192,438	93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-3,434	4,176,369	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	126,558	2,802,706	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-185,713,609	329,973,110	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	490,764	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.02	19302	UNUSED SPACE	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	6,601	193.03
193.04	19304	RENTED SPACE	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	8,728,888	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-185,713,609	339,199,363	200.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/28/2022 2:09 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,809,606	2,595,888		1.00
	0		1,809,606	2,595,888		
	B - RECLASS C-SECTION COSTS					
1.00	OPERATING ROOM	50.00	11,901	0		1.00
	0		11,901	0		
	C - RECLASS PORTION OF MED ONC DEPT					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	479,601	7,868		1.00
	0		479,601	7,868		
	D - RECLASS CAPITAL RELATED INSURANCE					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	38,039		1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	73,062		2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	105,534		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,066		4.00
	0		0	242,701		
	E - RECLASS VOLUNTEER SERVICES					
1.00	HOSPICE	116.00	15,347	2,555		1.00
	0		15,347	2,555		
	F - RECLASS HEALTH EDUCATION					
1.00	HEALTH EDUCATION	193.03	6,581	20		1.00
	0		6,581	20		
	G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	2,615,123		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	55,700		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	171,152		3.00
	0		0	2,841,975		
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,402,921		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,255,623		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	0		0	34,658,544		
	J - RECLASS PRECEPTOR PAY					
1.00	NURSING PROGRAM	20.00	962,328	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
			962,328	0		
	K - RECLASS RENT EXPENSE					
1.00	CAP REL COSTS-MOB PHASE I	1.04	0	73,179		1.00
			0	73,179		
	L - RECLASS LEASEHOLD IMP DEPR					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,515		1.00
2.00	RESPIRATORY THERAPY	65.00	0	12,491		2.00
3.00	LABORATORY	60.00	0	11,913		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	12,022		4.00
5.00	RETAIL PHARMACIES	193.05	0	3,236		5.00
			0	44,177		
	M - RECLASS OTHER PARAMEDIC PROGRAMS					
1.00	PARAMED ED PRGM-RESPIRATORY	23.04	171,207	100,270		1.00
2.00	PARAMED ED PRGM-HIM	23.05	182,705	156,852		2.00
3.00	PARAMED ED PRGM-LABORATORY	23.02	113,484	85,670		3.00
4.00	PARAMED ED PRGM-RADIOLOGY	23.01	31,682	262		4.00
5.00	ADULTS & PEDIATRICS	30.00	751,812	1,121,844		5.00
			1,250,890	1,464,898		
	N - RECLASS CONTRACTED HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	296,620		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,600		2.00
3.00		0.00	0	0		3.00
			0	300,220		
	O - RECLASS PHYSICAL THERAPIST WAGES					
1.00	PHYSICAL THERAPY	66.00	6,566	0		1.00
	TOTALS		6,566	0		
500.00	Grand Total: Increases		4,542,820	42,232,025		500.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet 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		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,809,606	2,595,888	0		1.00
	0		1,809,606	2,595,888			
	B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	11,901	0	0		1.00
	0		11,901	0			
	C - RECLASS PORTION OF MED ONC DEPT						
1.00	CLINIC	90.00	479,601	7,868	0		1.00
	0		479,601	7,868			
	D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	242,701	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	0		0	242,701			
	E - RECLASS VOLUNTEER SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	15,347	2,555	0		1.00
	0		15,347	2,555			
	F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	6,581	20	0		1.00
	0		6,581	20			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,841,975	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	0		0	2,841,975			
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	102,577	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	278,242	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	3,235	0		3.00
4.00	NURSERY	43.00	0	20,608	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	7,283	0		5.00
6.00	OPERATING ROOM	50.00	0	23,745,940	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	107,658	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	357,543	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	243,197	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,278	0		10.00
11.00	CT SCAN	57.00	0	73,555	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,568	0		12.00
13.00	LABORATORY	60.00	0	86,684	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	500,112	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	991	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	70	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	696	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	8,947,681	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,715	0		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	131	0		20.00
21.00	RENAL DIALYSIS	74.00	0	18	0		21.00
22.00	RURAL HEALTH CLINIC	88.00	0	419	0		22.00
23.00	CLINIC	90.00	0	506	0		23.00
24.00	OUTPATIENT INFUSION	90.01	0	2,317	0		24.00
25.00	ONCOLOGY	90.02	0	2,624	0		25.00
26.00	EMERGENCY	91.00	0	152,296	0		26.00
27.00	HOME HEALTH AGENCY	101.00	0	6,365	0		27.00
28.00	HOSPICE	116.00	0	7,235	0		28.00
	0		0	34,658,544			
	J - RECLASS PRECEPTOR PAY						
1.00	NURSING ADMINISTRATION	13.00	81,388	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	389,848	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	133,994	0	0		3.00
4.00	SUBPROVIDER - IRF	41.00	13,980	0	0		4.00
5.00	NURSERY	43.00	44,657	0	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	23,912	0	0		6.00
7.00	OPERATING ROOM	50.00	75,354	0	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	20,611	0	0		8.00
9.00	RESPIRATORY THERAPY	65.00	26,769	0	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	38,578	0	0		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	6,104	0	0		11.00
12.00	EMERGENCY	91.00	93,245	0	0		12.00
13.00	HOME HEALTH AGENCY	101.00	13,583	0	0		13.00
14.00	HOSPICE	116.00	305	0	0		14.00
	0		962,328	0			

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

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		
	K - RECLASS RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,179	10		1.00
	0		0	73,179			
	L - RECLASS LEASEHOLD IMP DEPR						
1.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	16,537	9		1.00
2.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	27,640	9		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		0	44,177			
	M - RECLASS OTHER PARAMEDIC PROGRAMS						
1.00	NURSING PROGRAM	20.00	1,250,890	1,464,898	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		1,250,890	1,464,898			
	N - RECLASS CONTRACTED HOUSEKEEPING						
1.00	NURSING PROGRAM	20.00	0	52,800	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	243,820	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3,600	0		3.00
	0		0	300,220			
	O - RECLASS PHYSICAL THERAPIST WAGES						
1.00	RURAL HEALTH CLINIC	88.00	6,566	0	0		1.00
	TOTALS		6,566	0			
500.00	Grand Total: Decreases		4,542,820	42,232,025			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	16,129,929	126,766	0	126,766	0	1.00
2.00	Land Improvements	9,837,381	1,112,669	0	1,112,669	0	2.00
3.00	Buildings and Fixtures	151,530,708	15,492,505	0	15,492,505	1,869,241	3.00
4.00	Building Improvements	3,531,182	0	0	0	0	4.00
5.00	Fixed Equipment	101,455,436	45,086,959	0	45,086,959	1,783,524	5.00
6.00	Movable Equipment	206,615,643	20,221,635	0	20,221,635	2,082,970	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	489,100,279	82,040,534	0	82,040,534	5,735,735	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	489,100,279	82,040,534	0	82,040,534	5,735,735	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	16,256,695	0				
2.00	Land Improvements	10,950,050	0				
3.00	Buildings and Fixtures	165,153,972	0				
4.00	Building Improvements	3,531,182	0				
5.00	Fixed Equipment	144,758,871	0				
6.00	Movable Equipment	224,754,308	0				
7.00	HIT designated Assets	0	0				
8.00	Subtotal (sum of lines 1-7)	565,405,078	0				
9.00	Reconciling Items	0	0				
10.00	Total (line 8 minus line 9)	565,405,078	0				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	660	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	8,161,417	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1,789,235	0	0	0	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0	0	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	13,680,388	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	23,631,700	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	660				1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	8,161,417				1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1,789,235				1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0				1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0				1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0				1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0				1.07
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,680,388				2.00
3.00	Total (sum of lines 1-2)	0	23,631,700				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	41,946	0	41,946	0.000078	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	264,714,344	0	264,714,344	0.491853	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	48,687,734	0	48,687,734	0.090464	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0.000000	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0.000000	0	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	224,754,308	0	224,754,308	0.417605	0	2.00
3.00	Total (sum of lines 1-2)	538,198,332	0	538,198,332	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	9,470	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	0	362,597	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	8,076,755	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	11,559	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	754,445	74,870	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	122,127	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	536,846	0	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	17,981,687	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	27,843,927	86,429	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)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	38,039	0	0	47,509	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	73,062	0	0	435,659	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1	105,534	0	0	8,182,290	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	11,559	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	829,315	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	122,127	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0	536,846	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	45,096	26,066	0	0	18,052,849	2.00
3.00	Total (sum of lines 1-2)	45,097	242,701	0	0	28,218,154	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			0CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BLDG & FIXTURES (chapter 2)			0CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BLDG & FIXTURES (chapter 2)			0CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			0CAP REL COSTS-MOB PHASE I	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-OAK STREET MALL (chapter 2)			0CAP REL COSTS-OAK STREET MALL	1.05	0	1.05
1.06	Investment income - CAP REL COSTS-BRCN AT 36TH ST (chapter 2)			0CAP REL COSTS-BRCN AT 36TH ST	1.06	0	1.06
1.07	Investment income - CAP REL COSTS-SURGERY CENTER (chapter 2)			0CAP REL COSTS-SURGERY CENTER	1.07	0	1.07
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-250,919	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-39,783	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-34,139,501			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	-23,235,700			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,490,093	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-372,572	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-104,608	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-316,945	NURSING PROGRAM	20.00	0	19.00
20.00	Vending machines	B	-12,516	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 2:09 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
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
26.01 Depreciation - CAP REL COSTS-BUTLER BUILDING			0 CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01
26.02 Depreciation - CAP REL COSTS-OLD BLDG & FIXTURES			0 CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	26.02
26.03 Depreciation - CAP REL COSTS-NEW BLDG & FIXTURES			0 CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	26.03
26.04 Depreciation - CAP REL COSTS-MOB PHASE I			0 CAP REL COSTS-MOB PHASE I	1.04	0	26.04
26.05 Depreciation - CAP REL COSTS-OAK STREET MALL			0 CAP REL COSTS-OAK STREET MALL	1.05	0	26.05
26.06 Depreciation - CAP REL COSTS-BRCN AT 36TH ST			0 CAP REL COSTS-BRCN AT 36TH ST	1.06	0	26.06
26.07 Depreciation - CAP REL COSTS-SURGERY CENTER			0 CAP REL COSTS-SURGERY CENTER	1.07	0	26.07
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 OCCUPATIONAL THERAPY	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 SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00 RENTAL INSURANCE EXPENSE	A	-15,308	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 DAMAGED GOODS	B	103,938	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 CHILD CARE CENTER	B	-2,224,739	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03 BOOKKEEPING FEES	B	-174,230	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 RADIOLOGY TUITION	B	-36,877	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.04
33.05 PRINT SHOP	B	-82,953	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 HEALTH PROMOTIONS	B	-73,188	NURSING ADMINISTRATION	13.00	0	33.06
33.07 HOUSEKEEPING SERVICES	B	-52,684	HOUSEKEEPING	9.00	0	33.07
33.08 ADVERTISING	A	-1,523,958	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 ADVERTISING	A	-77	DIETARY	10.00	0	33.09
33.10 ADVERTISING	A	-76,701	NURSING PROGRAM	20.00	0	33.10
33.11 ADVERTISING	A	-996	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12 ADVERTISING	A	-150	RURAL HEALTH CLINIC	88.00	0	33.12
33.13 ADVERTISING	A	-3,434	HOME HEALTH AGENCY	101.00	0	33.13
33.14 RENTAL PROPERTY EXPENSE	A	-187,122	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.14
33.15 REAL ESTATE TAXES ON RENTAL	A	-250,505	MAINTENANCE & REPAIRS	6.00	0	33.15
33.16 RENTAL PROPERTY EXPENSE	A	-23,037	MAINTENANCE & REPAIRS	6.00	0	33.16
33.17 INTEREST INCOME	A	-2,615,122	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11	33.17
33.18 INTEREST INCOME	A	-10,604	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.18
33.19 INTEREST INCOME	A	-171,152	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20 DIETARY OUTSIDE SERVICES-SALARIES	A	-46,904	DIETARY	10.00	0	33.20
33.21 DIETARY OUTSIDE SERVICES-BENEFITS	A	-15,267	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22 PHYSICIAN RECRUITMENT	A	-146,747	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23 LOBBYING EXPENSE	A	-54,302	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24 TRANSFER TO PARENT	A	-9,219,006	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25 HOSPICE PROFESSIONAL FEES	A	-18,398	HOSPICE	116.00	0	33.25
33.26 NURSING SCHOOL TUITION	A	-3,569,581	NURSING PROGRAM	20.00	0	33.26
33.27 LAB SCHOOL TUITION	B	-93,398	PARAMED ED PRGM-LABORATORY	23.02	0	33.27
33.28 HIM SCHOOL TUITION	B	-90,719	PARAMED ED PRGM-HIM	23.05	0	33.28
33.29 RT SCHOOL TUITION	B	-68,544	PARAMED ED PRGM-RESPIRATORY	23.04	0	33.29
33.30 RADIOLOGY SCHOOL TUITION	B	-1,423	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.30
33.31 MISCELLANEOUS INCOME	B	-580	NURSING PROGRAM	20.00	0	33.31
33.32 ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.32

Worksheet A-8

Date/Time Prepared:
2/28/2022 2:09 pm

				Expense Classification on Worksheet A		To/From Which the Amount is to be Adjusted			
Cost Center Description		Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.		
		1.00	2.00	3.00		4.00	5.00		
33.33	BOOK TO MEDICARE DEPRECIATION	A	40,874	CAP REL COSTS-NEW BLDG & FIXTURES		1.03		9	33.33
33.34	GROUPS FEES	B	-144,300	MAINTENANCE & REPAIRS		6.00		0	33.34
33.35	SELF-FUNDED HEALTH INSURANCE	A	-29,180,926	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.35
33.36	LEASED EQUIPMENT	B	-11,853	CAP REL COSTS-MVBLE EQUIP		2.00		9	33.36
33.37	TRAUMA ON-CALL	A	-934,903	ADMINISTRATIVE & GENERAL		5.00		0	33.37
33.38	NON-HOSPITAL DEPRECIATION	A	-464,005	CAP REL COSTS-MVBLE EQUIP		2.00		9	33.38
33.39	MISCELLANEOUS INCOME	B	-54,610	MEDICAL RECORDS & LIBRARY		16.00		0	33.39
33.40	MISCELLANEOUS INCOME	B	-52,250	ADMINISTRATIVE & GENERAL		5.00		0	33.40
33.41	MISCELLANEOUS INCOME	B	620	RESPIRATORY THERAPY		65.00		0	33.41
33.42	MISCELLANEOUS INCOME	B	-11,297	ADMINISTRATIVE & GENERAL		5.00		0	33.42
33.43	MISCELLANEOUS INCOME	B	-53,003	ADMINISTRATIVE & GENERAL		5.00		0	33.43
33.44	MISCELLANEOUS INCOME	B	-14,796	DRUGS CHARGED TO PATIENTS		73.00		0	33.44
33.45	MISCELLANEOUS INCOME	B	-1,459	ELECTROCARDIOLOGY		69.00		0	33.45
33.46	MISCELLANEOUS INCOME	B	-15,137	RADIOLOGY-DIAGNOSTIC		54.00		0	33.46
33.47	MISCELLANEOUS INCOME	B	-653	OPERATING ROOM		50.00		0	33.47
33.48	DOCTORS LOUNGE REVENUE	B	-142,284	DIETARY		10.00		0	33.48
33.49	CARE COORDINATION	B	-159,490	ADMINISTRATIVE & GENERAL		5.00		0	33.49
33.50	MISCELLANEOUS INCOME	B	-1,218,591	ADMINISTRATIVE & GENERAL		5.00		0	33.50
33.51	MISCELLANEOUS INCOME	B	140,792	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00		0	33.51
33.52	OUTSIDE CATERING	B	-19,839	DIETARY		10.00		0	33.52
33.53	BH JAVA	B	-525,547	DIETARY		10.00		0	33.53
33.54	EMG RENTAL	B	-45,539	ELECTROENCEPHALOGRAPHY		70.00		0	33.54
33.55	BPS EXPENSES	B	-58,500,240	ADMINISTRATIVE & GENERAL		5.00		0	33.55
33.56	PHARMACY COVERAGE SALARIES	A	-65,250	DRUGS CHARGED TO PATIENTS		73.00		0	33.56
33.57	PHARMACY COVERAGE BENEFITS	A	-21,239	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.57
33.58	PHARMACY COVERAGE EXPENSES	A	-16,474	DRUGS CHARGED TO PATIENTS		73.00		0	33.58
33.59	INTEREST FROM INSURANCE	B	-532,303	ADMINISTRATIVE & GENERAL		5.00		0	33.59
33.60	OTHER OPERATING EXPENSES	A	61,984	ADMINISTRATIVE & GENERAL		5.00		0	33.60
33.61	OTHER A&G EXPENSES	A	88,771	ADMINISTRATIVE & GENERAL		5.00		0	33.61
33.62	PA AND NP IN EMERGENCY DEPARTMENT	A	-807,031	EMERGENCY		91.00		0	33.62
33.63	PA AND NP IN SURGERY	A	-228,475	OPERATING ROOM		50.00		0	33.63
33.64	PA AND NP IN ONCOLOGY	A	-67,504	CLINIC		90.00		0	33.64
33.65	PA AND NP IN ADULTS & PEDS	A	-502,576	ADULTS & PEDIATRICS		30.00		0	33.65
33.66	PA AND NP IN ICU	A	-297,052	INTENSIVE CARE UNIT		31.00		0	33.66
33.67	PA AND NP IN CLINIC	A	-63,148	CLINIC		90.00		0	33.67
33.68	PA AND NP BENEFITS	A	-639,863	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.68
33.69	COLLEGE OF NURSING LOBBYING	A	-14,400	NURSING PROGRAM		20.00		0	33.69
33.70	LOBBYING EXPENSE	A	-2,576	SUBPROVIDER - IRF		41.00		0	33.70
33.71	MISCELLANEOUS INCOME	B	-59,750	DRUGS CHARGED TO PATIENTS		73.00		0	33.71
33.72	MISCELLANEOUS INCOME	B	-7,017	RESPIRATORY THERAPY		65.00		0	33.72
33.73	MISCELLANEOUS INCOME	B	-77,799	MAINTENANCE & REPAIRS		6.00		0	33.73
33.74	MISCELLANEOUS INCOME	B	-45,426	EMERGENCY		91.00		0	33.74
33.75	HOSPITAL SERVICES TO HOSPICE PTS	A	144,956	HOSPICE		116.00		0	33.75
33.76	ER PHYSICIAN BENEFITS	A	-524,116	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.76
33.77	CV SURGEON BENEFITS	A	-76,040	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.77
33.78	ONCOLOGIST BENEFITS	A	-271,310	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.78
33.79	HOSPITALIST BENEFITS	A	-308,913	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.79
33.80	INTENSIVIST BENEFITS	A	-90,739	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.80
33.81	CARDIOLOGIST BENEFITS	A	-58,878	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.81
33.82	DEPRECIATION ADJUSTMENT	A	8,810	CAP REL COSTS-BUTLER BUILDING		1.01		9	33.82
33.83	DEPRECIATION ADJUSTMENT	A	-7,713,980	CAP REL COSTS-OLD BLDG & FIXTURES		1.02		9	33.83
33.84	DEPRECIATION ADJUSTMENT	A	9,003,986	CAP REL COSTS-NEW BLDG & FIXTURES		1.03		9	33.84
33.85	DEPRECIATION ADJUSTMENT	A	754,445	CAP REL COSTS-OAK STREET MALL		1.05		9	33.85
33.86	DEPRECIATION ADJUSTMENT	A	122,127	CAP REL COSTS-BRCN AT 36TH ST		1.06		9	33.86
33.87	DEPRECIATION ADJUSTMENT	A	536,846	CAP REL COSTS-SURGERY CENTER		1.07		9	33.87
33.88	DEPRECIATION ADJUSTMENT	A	4,816,940	CAP REL COSTS-MVBLE EQUIP		2.00		9	33.88
33.89	DEPRECIATION ADJUSTMENT	A	-2,542,578	CAP REL COSTS-NEW BLDG & FIXTURES		1.03		9	33.89
33.90	DEPRECIATION ADJUSTMENT	A	-68,303	CAP REL COSTS-OLD BLDG & FIXTURES		1.02		9	33.90
33.91	CONTRACTED HOUSEKEEPING	A	-61,915	HOUSEKEEPING		9.00		0	33.91

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.92	PROVIDER TAX	A	-12,156,580	ADMINISTRATIVE & GENERAL	5.00	0	33.92
33.93	COMMUNITY BENEFIT	A	-1,023,367	ADMINISTRATIVE & GENERAL	5.00	0	33.93
33.94	TUITION FOR SOPHOMORE STUDENTS	B	-483,488	ADULTS & PEDIATRICS	30.00	0	33.94
33.95	SNU PHYSICIAN	A	-531	SKILLED NURSING FACILITY	44.00	0	33.95
33.96	RENT ON UNUSED SPACE	A	-68,007	ADMINISTRATIVE & GENERAL	5.00	0	33.96
33.97	MISCELLANEOUS INCOME	B	-33,776	DRUGS CHARGED TO PATIENTS	73.00	0	33.97
33.98	MISCELLANEOUS INCOME	B	-18,151	ADMINISTRATIVE & GENERAL	5.00	0	33.98
33.99	48TH AND MAINE ADMINISTRATION	A	-226,078	MAINTENANCE & REPAIRS	6.00	0	33.99
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-185,713,609				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 2:09 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED MAINTENANCE	676,795	1,609,500	1.00
2.00	30.00	ADULTS & PEDIATRICS	BIO-MED MAINTENANCE	11	27	2.00
3.00	50.00	OPERATING ROOM	BIO-MED MAINTENANCE	6,910	16,433	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED MAINTENANCE	775	1,842	4.00
4.01	90.00	CLINIC	BIO-MED MAINTENANCE	383	912	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,675,442	1,707,544	4.02
4.03	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	37,533	86,582	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	44,484,849	20,198,912	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	6,746,001	0	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	197,984	4.06
4.07	1.04	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	11,559	73,179	4.07
4.08	10.00	DIETARY	DIETICIAN COSTS	0	2,891	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEFITS	0	941	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	DATA ANALYTICS WAGES	0	1,341,042	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	FISCAL SERVICES WAGES	0	1,081,857	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES WAGES	0	951,324	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS WAGES	0	7,436,511	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PURCHASING WAGES	0	833,716	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED DEPTS BENEFITS	0	6,523,807	4.15
4.16	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT WAGES	0	3,824,670	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	DATA ANALYTICS EXPENSES	0	211,301	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	FISCAL SERVICES EXPENSES	0	142,971	4.18
4.19	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES EXPENSES	0	560,290	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS EXPENSES	0	12,655,786	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	PURCHASING EXPENSES	0	928,829	4.21
4.22	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT EXPENSES	0	4,380	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY	HIM WAGES	0	4,098,897	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	PFS WAGES	0	3,847,507	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	PT ACCESS WAGES	0	2,711,209	4.25
4.26	4.00	EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE BENEFITS	0	6,737,083	4.26
4.27	16.00	MEDICAL RECORDS & LIBRARY	HIM EXPENSES	0	1,080,223	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	PFS EXPENSES	0	3,261,597	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	PT ACCESS EXPENSES	0	117,830	4.29
4.30	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES WAGES	0	18,420	4.30
4.31	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDIES BENEFITS	0	5,996	4.31
4.32	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES EXPENSES	0	2,080	4.32
4.33	30.00	ADULTS & PEDIATRICS	TELEMETRY WAGES	0	27,794	4.33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEMETRY BENEFITS	0	9,047	4.34
4.35	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER WAGES	0	62,164	4.35
4.36	4.00	EMPLOYEE BENEFITS DEPARTMENT	LOGISTICS MANAGER BENEFITS	0	20,234	4.36
4.37	5.00	ADMINISTRATIVE & GENERAL	OAK STREET MALL	0	100,225	4.37
4.38	1.05	CAP REL COSTS-OAK STREET MAL	OAK STREET MALL	150,640	0	4.38
4.39	1.05	CAP REL COSTS-OAK STREET MAL	BBC RENT FOR HIM, PFS, PT AC	0	75,770	4.39
4.40	13.00	NURSING ADMINISTRATION	HOME OFFICE	5,097,456	0	4.40
4.41	88.00	RURAL HEALTH CLINIC	HOME OFFICE	31,248	0	4.41
4.42	60.00	LABORATORY	MOLECULAR LAB	784,645	370,640	4.42
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			59,704,247	82,939,947	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.

Positive amounts increase cost and negative amounts decrease cost.

For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 2:09 pm

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

reimbursement under title XVIII.

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

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

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

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

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 2:09 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-932,705	0		1.00
2.00	-16	0		2.00
3.00	-9,523	0		3.00
4.00	-1,067	0		4.00
4.01	-529	0		4.01
4.02	-32,102	0		4.02
4.03	-49,049	0		4.03
4.04	24,285,937	0		4.04
4.05	6,746,001	0		4.05
4.06	-197,984	0		4.06
4.07	-61,620	10		4.07
4.08	-2,891	0		4.08
4.09	-941	0		4.09
4.10	-1,341,042	0		4.10
4.11	-1,081,857	0		4.11
4.12	-951,324	0		4.12
4.13	-7,436,511	0		4.13
4.14	-833,716	0		4.14
4.15	-6,523,807	0		4.15
4.16	-3,824,670	0		4.16
4.17	-211,301	0		4.17
4.18	-142,971	0		4.18
4.19	-560,290	0		4.19
4.20	-12,655,786	0		4.20
4.21	-928,829	0		4.21
4.22	-4,380	0		4.22
4.23	-4,098,897	0		4.23
4.24	-3,847,507	0		4.24
4.25	-2,711,209	0		4.25
4.26	-6,737,083	0		4.26
4.27	-1,080,223	0		4.27
4.28	-3,261,597	0		4.28
4.29	-117,830	0		4.29
4.30	-18,420	0		4.30
4.31	-5,996	0		4.31
4.32	-2,080	0		4.32
4.33	-27,794	0		4.33
4.34	-9,047	0		4.34
4.35	-62,164	0		4.35
4.36	-20,234	0		4.36
4.37	-100,225	0		4.37
4.38	150,640	10		4.38
4.39	-75,770	10		4.39
4.40	5,097,456	0		4.40
4.41	31,248	0		4.41
4.42	414,005	0		4.42
5.00	-23,235,700			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.

Positive amounts increase cost and negative amounts decrease cost.

For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00

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

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 2:09 pm

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		9.00
10.00	LABORATORY		10.00
100.00			100.00

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

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 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
 E. Individual is director, officer, administrator, or key person of provider and related organization.
 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 2:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,206,816	3,889,490	317,326	211,500	1,975	1.00
2.00	90.00	CLINIC	25,813	25,813	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	553,208	553,208	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	2,758,873	2,758,873	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	2,025	0	2,025	211,500	14	5.00
6.00	30.00	ADULTS & PEDIATRICS	50,750	0	50,750	211,500	254	6.00
7.00	30.00	ADULTS & PEDIATRICS	1,697,279	1,697,279	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	18,131	0	18,131	211,500	121	8.00
9.00	31.00	INTENSIVE CARE UNIT	18,131	0	18,131	237,100	121	9.00
10.00	31.00	INTENSIVE CARE UNIT	1,009,397	1,009,397	0	0	0	10.00
11.00	31.00	INTENSIVE CARE UNIT	2,025	0	2,025	211,500	14	11.00
12.00	31.00	INTENSIVE CARE UNIT	47,150	0	47,150	246,400	240	12.00
13.00	30.00	ADULTS & PEDIATRICS	17,370	0	17,370	181,300	97	13.00
14.00	41.00	SUBPROVIDER - IRF	36,000	0	36,000	211,500	288	14.00
15.00	50.00	OPERATING ROOM	24,000	0	24,000	211,500	120	15.00
16.00	53.00	ANESTHESIOLOGY	26,140	26,140	0	0	0	16.00
17.00	65.00	RESPIRATORY THERAPY	6,450	0	6,450	211,500	43	17.00
18.00	65.00	RESPIRATORY THERAPY	6,825	0	6,825	211,500	46	18.00
19.00	70.00	ELECTROENCEPHALOGRAPHY	6,975	0	6,975	211,500	47	19.00
20.00	69.00	ELECTROCARDIOLOGY	2,188	0	2,188	211,500	17	20.00
21.00	69.00	ELECTROCARDIOLOGY	17,896	0	17,896	246,400	80	21.00
22.00	91.00	EMERGENCY	31,200	0	31,200	211,500	240	22.00
23.00	91.00	EMERGENCY	579,860	517,460	62,400	211,500	511	23.00
24.00	91.00	EMERGENCY	5,322,028	5,322,028	0	0	0	24.00
25.00	91.00	EMERGENCY	202,900	0	202,900	211,500	1,088	25.00
26.00	50.00	OPERATING ROOM	5,742	0	5,742	211,500	26	26.00
27.00	90.00	CLINIC	5,345	0	5,345	211,500	42	27.00
28.00	90.00	CLINIC	2,527,165	2,527,165	0	0	0	28.00
29.00	5.00	ADMINISTRATIVE & GENERAL	12,897,297	12,897,297	0	0	0	29.00
30.00	54.00	RADIOLOGY-DIAGNOSTIC	1,280,134	1,280,134	0	0	0	30.00
31.00	50.00	OPERATING ROOM	309,411	309,411	0	0	0	31.00
32.00	50.00	OPERATING ROOM	997,889	997,889	0	0	0	32.00
200.00			34,692,413	33,811,584	880,829		5,384	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 2:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	200,823	10,041	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	1,424	71	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	25,827	1,291	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	12,304	615	0	0	0	8.00
9.00	31.00	INTENSIVE CARE UNIT	13,793	690	0	0	0	9.00
10.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	10.00
11.00	31.00	INTENSIVE CARE UNIT	1,424	71	0	0	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	28,431	1,422	0	0	0	12.00
13.00	30.00	ADULTS & PEDIATRICS	8,455	423	0	0	0	13.00
14.00	41.00	SUBPROVIDER - IRF	29,285	1,464	0	0	0	14.00
15.00	50.00	OPERATING ROOM	12,202	610	0	0	0	15.00
16.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	16.00
17.00	65.00	RESPIRATORY THERAPY	4,372	219	0	0	0	17.00
18.00	65.00	RESPIRATORY THERAPY	4,677	234	0	0	0	18.00
19.00	70.00	ELECTROENCEPHALOGRAPHY	4,779	239	0	0	0	19.00
20.00	69.00	ELECTROCARDIOLOGY	1,729	86	0	0	0	20.00
21.00	69.00	ELECTROCARDIOLOGY	9,477	474	0	0	0	21.00
22.00	91.00	EMERGENCY	24,404	1,220	0	0	0	22.00
23.00	91.00	EMERGENCY	51,960	2,598	0	0	0	23.00
24.00	91.00	EMERGENCY	0	0	0	0	0	24.00
25.00	91.00	EMERGENCY	110,631	5,532	0	0	0	25.00
26.00	50.00	OPERATING ROOM	2,644	132	0	0	0	26.00
27.00	90.00	CLINIC	4,271	214	0	0	0	27.00
28.00	90.00	CLINIC	0	0	0	0	0	28.00
29.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	29.00
30.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	30.00
31.00	50.00	OPERATING ROOM	0	0	0	0	0	31.00
32.00	50.00	OPERATING ROOM	0	0	0	0	0	32.00
200.00			552,912	27,646	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 2:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	200,823	116,503	4,005,993		1.00
2.00	90.00	CLINIC	0	0	0	25,813		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	553,208		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,758,873		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	1,424	601	601		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	25,827	24,923	24,923		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,697,279		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	12,304	5,827	5,827		8.00
9.00	31.00	INTENSIVE CARE UNIT	0	13,793	4,338	4,338		9.00
10.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,009,397		10.00
11.00	31.00	INTENSIVE CARE UNIT	0	1,424	601	601		11.00
12.00	31.00	INTENSIVE CARE UNIT	0	28,431	18,719	18,719		12.00
13.00	30.00	ADULTS & PEDIATRICS	0	8,455	8,915	8,915		13.00
14.00	41.00	SUBPROVIDER - IRF	0	29,285	6,715	6,715		14.00
15.00	50.00	OPERATING ROOM	0	12,202	11,798	11,798		15.00
16.00	53.00	ANESTHESIOLOGY	0	0	0	26,140		16.00
17.00	65.00	RESPIRATORY THERAPY	0	4,372	2,078	2,078		17.00
18.00	65.00	RESPIRATORY THERAPY	0	4,677	2,148	2,148		18.00
19.00	70.00	ELECTROENCEPHALOGRAPHY	0	4,779	2,196	2,196		19.00
20.00	69.00	ELECTROCARDIOLOGY	0	1,729	459	459		20.00
21.00	69.00	ELECTROCARDIOLOGY	0	9,477	8,419	8,419		21.00
22.00	91.00	EMERGENCY	0	24,404	6,796	6,796		22.00
23.00	91.00	EMERGENCY	0	51,960	10,440	527,900		23.00
24.00	91.00	EMERGENCY	0	0	0	5,322,028		24.00
25.00	91.00	EMERGENCY	0	110,631	92,269	92,269		25.00
26.00	50.00	OPERATING ROOM	0	2,644	3,098	3,098		26.00
27.00	90.00	CLINIC	0	4,271	1,074	1,074		27.00
28.00	90.00	CLINIC	0	0	0	2,527,165		28.00
29.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	12,897,297		29.00
30.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,280,134		30.00
31.00	50.00	OPERATING ROOM	0	0	0	309,411		31.00
32.00	50.00	OPERATING ROOM	0	0	0	997,889		32.00
200.00			0	552,912	327,917	34,139,501		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES		NEW BLDG & FIXTURES
0			1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0			1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING	47,509	0	47,509		1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	435,659	0	0	435,659	1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	8,182,290	0	0	0	1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I	11,559	0	0	0	1.04	
1.05	00105	CAP REL COSTS-OAK STREET MALL	829,315	0	0	0	1.05	
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	122,127	0	0	0	1.06	
1.07	00107	CAP REL COSTS-SURGERY CENTER	536,846	0	0	0	1.07	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	18,052,849				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,653,828	0	0	13,182	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	68,746,318	0	8,223	105,159	5.00	
6.00	00600	MAINTENANCE & REPAIRS	9,776,701	0	0	71,974	6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,735,609	0	0	6,885	8.00	
9.00	00900	HOUSEKEEPING	4,952,171	0	0	14,251	9.00	
10.00	01000	DIETARY	2,171,066	0	0	0	10.00	
11.00	01100	CAFETERIA	2,915,401	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	10,771,373	0	0	15,582	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	6,586,784	0	0	2,099	16.00	
20.00	02000	NURSING PROGRAM	2,281,537	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,101,295	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,127,070	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00	
23.01	02301	PARAMED ED PRGM-RADIOLOGY	239,657	0	0	0	23.01	
23.02	02302	PARAMED ED PRGM-LABORATORY	105,756	0	0	0	23.02	
23.03	02303	PARAMED ED PRGM-PHARMACY	363,610	0	0	0	23.03	
23.04	02304	PARAMED ED PRGM-RESPIRATORY	202,933	0	0	0	23.04	
23.05	02305	PARAMED ED PRGM-HIM	248,838	0	0	0	23.05	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,803,207	0	0	366	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,903,616	0	0	35,563	31.00	
41.00	04100	SUBPROVIDER - IRF	1,868,172	0	0	17,003	41.00	
43.00	04300	NURSERY	311,569	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	1,765,682	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,315,001	0	0	25,155	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	809,068	0	0	28,865	52.00	
53.00	05300	ANESTHESIOLOGY	653,974	0	0	2,253	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,726,421	0	0	5,468	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,436,776	0	0	0	55.00	
57.00	05700	CT SCAN	829,052	0	0	2,142	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	555,014	0	0	0	58.00	
60.00	06000	LABORATORY	11,542,689	0	0	2,293	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,205,589	0	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	3,138,057	0	0	5,217	65.00	
66.00	06600	PHYSICAL THERAPY	1,545,889	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	881,374	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	270,956	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,287,054	0	0	29,435	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	599,016	0	0	6,462	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,907,927	0	15,184	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,255,623	0	24,102	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	28,739,089	0	0	409	73.00	
74.00	07400	RENAL DIALYSIS	1,143,642	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	809,558	0	0	0	88.00	
90.00	09000	CLINIC	1,580,662	0	0	0	90.00	
90.01	09001	OUTPATIENT INFUSION	482,623	0	0	0	90.01	
90.02	04950	ONCOLOGY	222,356	0	0	0	90.02	
91.00	09100	EMERGENCY	7,013,840	0	0	21,011	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	192,438	0	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,176,369	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	2,802,706	0	0	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	329,973,110	0	47,509	410,774	7,479,039	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
0			1.00	1.01	1.02	1.03		
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,524	10,827	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	490,764	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	13,584	193.01
193.02	19302	UNUSED SPACE	0	0	0	10,369	434,443	193.02
193.03	19303	HEALTH EDUCATION	6,601	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	2,992	240,539	193.04
193.05	19305	RETAIL PHARMACIES	8,728,888	0	0	0	3,858	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	339,199,363	0	47,509	435,659	8,182,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS					
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	11,559					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	829,315				1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	122,127			1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	0	0	0	536,846		1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP					18,052,849	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	127,893	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,559	538,842	0	83,224	8,387,736	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,112	0	81,517	341,934	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	3,107	8.00
9.00	00900	HOUSEKEEPING	0	420	0	2,814	161,062	9.00
10.00	01000	DIETARY	0	0	0	0	176,975	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	55,712	0	0	1,018,279	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,160	0	0	56,059	16.00
20.00	02000	NURSING PROGRAM	0	55,238	84,257	0	151,236	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	751	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,312	0	0	7,946	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	1,897	2,884	0	5,179	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	2,209	3,367	0	6,042	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	3,469	5,288	0	9,493	23.05
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	17,265	26,331	0	760,277	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	155,066	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	7,544	41.00
43.00	04300	NURSERY	0	0	0	0	17,624	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	1,007	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	369,291	2,569,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	24,915	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	94,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	433,874	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	670,496	55.00
57.00	05700	CT SCAN	0	0	0	0	516,633	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	60,631	58.00
60.00	06000	LABORATORY	0	0	0	0	310,768	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	16,488	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	261,204	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	7,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,083	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,408	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	614,234	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	60,391	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	76,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	116,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	495,346	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3,831	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	139	88.00
90.00	09000	CLINIC	0	0	0	0	83,019	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	31,237	0	0	112,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	7,460	93.99
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	27,782	0	0	642	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	7,103	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,559	820,655	122,127	536,846	17,943,305	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	61,858	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS					
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	8,660	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	0	47,686	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,559	829,315	122,127	536,846	18,052,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	6.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,870,405					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	780,586	80,226,953	80,226,953			5.00
6.00	00600	MAINTENANCE & REPAIRS	281,164	11,551,622	3,578,577	15,130,199		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,295	1,768,199	547,770	87,811	2,403,780	8.00
9.00	00900	HOUSEKEEPING	245,588	5,403,611	1,673,985	160,426	24,335	9.00
10.00	01000	DIETARY	87,890	2,643,501	818,930	401,723	17,701	10.00
11.00	01100	CAFETERIA	138,290	3,135,890	971,467	159,085	0	11.00
13.00	01300	NURSING ADMINISTRATION	368,366	12,241,171	3,792,192	245,214	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,752,208	2,091,767	223,261	0	16.00
20.00	02000	NURSING PROGRAM	311,505	2,931,346	908,102	786,120	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	84,161	1,185,456	367,242	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,127,821	659,178	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	20,796	294,721	91,302	51,030	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	8,672	131,968	40,882	38,437	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	27,409	391,019	121,134	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	13,084	228,301	70,725	29,025	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	13,962	282,096	87,391	45,588	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,042,518	39,938,107	12,372,316	4,647,970	834,787	30.00
31.00	03100	INTENSIVE CARE UNIT	379,822	6,627,082	2,053,004	556,733	134,720	31.00
41.00	04100	SUBPROVIDER - IRF	131,506	2,089,091	647,180	250,130	130,712	41.00
43.00	04300	NURSERY	21,174	398,823	123,551	93,779	14,574	43.00
44.00	04400	SKILLED NURSING FACILITY	114,313	2,036,231	630,804	300,424	95,828	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	813,659	21,473,223	6,652,190	1,228,961	190,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,147	913,995	283,147	211,509	66,392	52.00
53.00	05300	ANESTHESIOLOGY	15,091	775,300	240,180	34,336	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,150	6,673,257	2,067,308	443,288	163,813	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	69,501	2,332,994	722,738	302,344	93,769	55.00
57.00	05700	CT SCAN	48,795	1,410,668	437,011	42,880	72,028	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,342	665,006	206,012	52,292	11,882	58.00
60.00	06000	LABORATORY	240,471	12,236,725	3,790,815	288,725	237	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,376	1,237,683	383,422	10,122	0	62.00
65.00	06500	RESPIRATORY THERAPY	205,804	3,615,811	1,120,142	48,927	0	65.00
66.00	06600	PHYSICAL THERAPY	116,875	1,716,254	531,678	89,336	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,631	974,394	301,858	43,169	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,577	300,494	93,090	14,618	0	68.00
69.00	06900	ELECTROCARDIOLOGY	182,847	4,178,164	1,294,353	340,702	95,480	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,943	705,812	218,653	47,350	727	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,989	16,109,662	4,990,612	172,599	12,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,752	21,578,900	6,684,927	273,766	19,443	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	383,353	29,686,282	9,196,513	134,766	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,147,473	355,476	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	39,750	849,447	263,150	0	0	88.00
90.00	09000	CLINIC	104,143	1,776,885	550,461	17,536	0	90.00
90.01	09001	OUTPATIENT INFUSION	32,474	562,629	174,297	91,991	791	90.01
90.02	04950	ONCOLOGY	14,348	248,509	76,986	22,847	0	90.02
91.00	09100	EMERGENCY	389,404	7,784,314	2,411,503	632,819	415,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	14,218	233,406	72,307	37,333	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	251,108	4,455,901	1,380,394	53,896	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	147,936	2,957,745	916,280	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,729,785	328,986,150	77,063,002	12,712,868	2,395,904	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,351	6,924	105,400	7,876	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,651	589,273	182,551	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	13,584	4,208	26,291	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	6.00	8.00	
193.02	19302	UNUSED SPACE	0	453,472	140,481	933,585	0	193.02
193.03	19303	HEALTH EDUCATION	503	7,104	2,201	0	0	193.03
193.04	19304	RENTED SPACE	0	243,531	75,443	1,344,588	0	193.04
193.05	19305	RETAIL PHARMACIES	103,466	8,883,898	2,752,143	7,467	0	193.05
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,870,405	339,199,363	80,226,953	15,130,199	2,403,780	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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From 10/01/2020
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	7,262,357					9.00
10.00	01000	DIETARY	231,455	4,113,310				10.00
11.00	01100	CAFETERIA	91,673	0	4,358,115			11.00
13.00	01300	NURSING ADMINISTRATION	141,318	0	242,770	16,662,665		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,661	0	0	0	9,195,897	16.00
20.00	02000	NURSING PROGRAM	452,956	0	165,447	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	58,585	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	29,431	0	10,897	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	22,119	0	4,855	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	14,673	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	16,712	0	7,505	0	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	26,298	0	2,937	0	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,678,170	3,239,597	1,452,373	8,180,819	7,203,404	30.00
31.00	03100	INTENSIVE CARE UNIT	320,793	362,107	226,034	1,273,136	805,166	31.00
41.00	04100	SUBPROVIDER - IRF	144,145	264,251	83,581	470,748	587,604	41.00
43.00	04300	NURSERY	54,008	0	11,113	62,588	13,668	43.00
44.00	04400	SKILLED NURSING FACILITY	173,084	247,355	87,009	490,058	549,964	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	708,129	0	509,599	2,870,356	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	121,903	0	32,799	184,739	0	52.00
53.00	05300	ANESTHESIOLOGY	19,785	0	16,304	91,845	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,418	0	183,716	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	174,190	0	28,220	0	0	55.00
57.00	05700	CT SCAN	24,700	0	26,829	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,107	0	12,947	0	0	58.00
60.00	06000	LABORATORY	166,387	0	180,875	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,837	0	7,564	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	28,202	0	125,670	0	0	65.00
66.00	06600	PHYSICAL THERAPY	51,489	0	58,406	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,884	0	35,485	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,418	0	9,662	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	196,310	0	100,328	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,281	0	28,184	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,626	0	31,493	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,573	0	55,133	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,664	0	176,991	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	10,077	0	45,842	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	53,025	0	20,452	115,176	0	90.01
90.02	04950	ONCOLOGY	13,149	0	10,442	58,805	0	90.02
91.00	09100	EMERGENCY	364,663	0	273,231	1,538,988	36,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	21,505	0	9,902	55,754	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	31,029	0	0	799,805	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	469,848	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,182,174	4,113,310	4,347,853	16,662,665	9,195,897	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	60,706	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,902	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	15,176	0	0	0	0	193.01

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	360	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	4,301	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,262,357	4,113,310	4,358,115	16,662,665	9,195,897	202.00

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Cost Center Description			INTERNS & RESIDENTS			PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
			NURSING PROGRAM	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
				20.00	21.00			
			23.00	23.01				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM	5,243,971					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		1,552,698				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			2,845,584			22.00
23.00	02300	PARAMED ED PRGM				0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY					477,381	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY						23.04
23.05	02305	PARAMED ED PRGM-HIM						23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,047,540	1,127,781	2,066,850	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	157,998	68,204	124,996	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	299,336	37,723	69,135	0	0	41.00
43.00	04300	NURSERY	71,768	39,006	71,485	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,465	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	158,365	55,982	102,596	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,810	3,621	6,637	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,621	6,637	0	477,381	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	14,637	26,824	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,465	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,991	51,298	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	43,835	80,335	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	6,591	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	38,447	0	0	0	0	90.01
90.02	04950	ONCOLOGY	1,465	0	0	0	0	90.02
91.00	09100	EMERGENCY	187,840	130,297	238,791	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	37,348	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,479			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,222,917	1,552,698	2,845,584	0	477,381	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,054	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
			NURSING PROGRAM	SERVICES-SALAR			
				Y & FRINGES	SERVICES-OTHER PRGM COSTS		
			20.00	21.00	22.00	23.00	23.01
193.01	19301	DENMAN SERVICES	0	0	0	0	0
193.02	19302	UNUSED SPACE	0	0	0	0	0
193.03	19303	HEALTH EDUCATION	0	0	0	0	0
193.04	19304	RENTED SPACE	0	0	0	0	0
193.05	19305	RETAIL PHARMACIES	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	5,243,971	1,552,698	2,845,584	0	477,381

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Cost Center Description			PARAMED ED PRGM-LABORATORY Y	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	
			23.02	23.03	23.04	23.05	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	238,261					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY		526,826				23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY			352,268			23.04
23.05	02305	PARAMED ED PRGM-HIM				444,310		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	348,041	88,137,755	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	38,902	12,748,875	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	28,391	5,102,027	41.00
43.00	04300	NURSERY	0	0	0	660	955,023	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	26,572	4,638,794	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	33,950,380	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	2,034,552	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,177,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	10,274,439	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	3,654,255	55.00
57.00	05700	CT SCAN	0	0	0	0	2,014,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	978,246	58.00
60.00	06000	LABORATORY	238,261	0	0	0	16,943,486	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,644,628	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	352,268	0	5,292,485	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,447,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,379,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	426,282	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	6,284,626	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1,152,177	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	21,418,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	28,767,742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	526,826	0	0	39,799,042	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,502,949	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,112,597	88.00
90.00	09000	CLINIC	0	0	0	0	2,407,392	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	1,056,808	90.01
90.02	04950	ONCOLOGY	0	0	0	0	432,203	90.02
91.00	09100	EMERGENCY	0	0	0	1,744	14,015,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	430,207	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	6,758,373	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	4,347,352	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	238,261	526,826	352,268	444,310	323,285,493	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	203,257	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	802,780	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	59,259	193.01

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Cost Center Description			PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	
			23.02	23.03	23.04	23.05	24.00	
193.02	19302	UNUSED SPACE	0	0	0	0	1,527,538	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	9,665	193.03
193.04	19304	RENTED SPACE	0	0	0	0	1,663,562	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	0	11,647,809	193.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	238,261	526,826	352,268	444,310	339,199,363	202.00

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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
1.01	00101	CAP REL COSTS-BUTLER BUILDING			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES			1.03
1.04	00104	CAP REL COSTS-MOB PHASE I			1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL			1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST			1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER			1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY			23.02
23.03	02303	PARAMED ED PRGM-PHARMACY			23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY			23.04
23.05	02305	PARAMED ED PRGM-HIM			23.05
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,194,631	84,943,124	30.00
31.00	03100	INTENSIVE CARE UNIT	-193,200	12,555,675	31.00
41.00	04100	SUBPROVIDER - IRF	-106,858	4,995,169	41.00
43.00	04300	NURSERY	-110,491	844,532	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,638,794	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-158,578	33,791,802	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-10,258	2,024,294	52.00
53.00	05300	ANESTHESIOLOGY	0	1,177,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,258	10,264,181	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,654,255	55.00
57.00	05700	CT SCAN	0	2,014,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	978,246	58.00
60.00	06000	LABORATORY	-41,461	16,902,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,644,628	62.00
65.00	06500	RESPIRATORY THERAPY	0	5,292,485	65.00
66.00	06600	PHYSICAL THERAPY	0	2,447,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,379,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	426,282	68.00
69.00	06900	ELECTROCARDIOLOGY	-79,289	6,205,337	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-124,170	1,028,007	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,418,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,767,742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,799,042	73.00
74.00	07400	RENAL DIALYSIS	0	1,502,949	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,112,597	88.00
90.00	09000	CLINIC	0	2,407,392	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,056,808	90.01
90.02	04950	ONCOLOGY	0	432,203	90.02
91.00	09100	EMERGENCY	-369,088	13,646,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	430,207	93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	6,758,373	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	4,347,352	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,398,282	318,887,211	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	203,257	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	802,780	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DENMAN SERVICES	0	59,259		193.01
193.02	19302	UNUSED SPACE	0	1,527,538		193.02
193.03	19303	HEALTH EDUCATION	0	9,665		193.03
193.04	19304	RENTED SPACE	0	1,663,562		193.04
193.05	19305	RETAIL PHARMACIES	0	11,647,809		193.05
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)	-4,398,282	334,801,081		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER					1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,812	0	13,182	75,502	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	784,568	0	105,159	1,565,306	5.00
6.00	00600	MAINTENANCE & REPAIRS	576	0	71,974	992,220	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	6,885	19,303	8.00
9.00	00900	HOUSEKEEPING	0	0	14,251	27,305	9.00
10.00	01000	DIETARY	9,693	0	0	207,570	10.00
11.00	01100	CAFETERIA	0	0	0	82,199	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	15,582	11,859	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,099	46,106	16.00
20.00	02000	NURSING PROGRAM	661,125	0	0	47,573	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	7,010	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	7,580	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	666	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	1,046	23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	109,511	0	366	2,288,143	30.00
31.00	03100	INTENSIVE CARE UNIT	22,952	0	35,563	153,015	31.00
41.00	04100	SUBPROVIDER - IRF	1,534	0	17,003	64,866	41.00
43.00	04300	NURSERY	0	0	0	48,456	43.00
44.00	04400	SKILLED NURSING FACILITY	11,692	0	0	155,229	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,105,654	0	25,155	381,111	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	28,865	0	52.00
53.00	05300	ANESTHESIOLOGY	30,871	0	2,253	9,210	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	318,380	0	5,468	208,344	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	156,221	55.00
57.00	05700	CT SCAN	0	0	2,142	14,046	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	27,019	58.00
60.00	06000	LABORATORY	15,759	0	2,293	140,504	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	5,230	62.00
65.00	06500	RESPIRATORY THERAPY	79,123	0	5,217	5,529	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	46,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	22,306	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,553	68.00
69.00	06900	ELECTROCARDIOLOGY	3,300	0	29,435	64,594	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,080	0	6,462	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,184	0	84,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,102	0	133,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	409	68,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	49,749	0	0	0	88.00
90.00	09000	CLINIC	109,245	0	0	9,061	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	47,532	90.01
90.02	04950	ONCOLOGY	0	0	0	11,805	90.02
91.00	09100	EMERGENCY	0	0	21,011	216,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	19,290	93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,130	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	178,795	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,566,549	0	47,509	410,774	7,479,039
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,524	10,827

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	13,584	193.01
193.02	19302	UNUSED SPACE	0	0	0	10,369	434,443	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	2,992	240,539	193.04
193.05	19305	RETAIL PHARMACIES	29,105	0	0	0	3,858	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,595,654	0	47,509	435,659	8,182,290	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			CAPITAL RELATED COSTS					
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	127,893	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,559	538,842	0	83,224	8,387,736	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,112	0	81,517	341,934	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	3,107	8.00
9.00	00900	HOUSEKEEPING	0	420	0	2,814	161,062	9.00
10.00	01000	DIETARY	0	0	0	0	176,975	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	55,712	0	0	1,018,279	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,160	0	0	56,059	16.00
20.00	02000	NURSING PROGRAM	0	55,238	84,257	0	151,236	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	751	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,312	0	0	7,946	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	1,897	2,884	0	5,179	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	2,209	3,367	0	6,042	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	3,469	5,288	0	9,493	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	17,265	26,331	0	760,277	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	155,066	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	7,544	41.00
43.00	04300	NURSERY	0	0	0	0	17,624	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	1,007	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	369,291	2,569,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	24,915	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	94,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	433,874	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	670,496	55.00
57.00	05700	CT SCAN	0	0	0	0	516,633	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	60,631	58.00
60.00	06000	LABORATORY	0	0	0	0	310,768	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	16,488	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	261,204	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	7,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,083	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,408	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	614,234	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	60,391	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	76,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	116,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	495,346	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3,831	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	139	88.00
90.00	09000	CLINIC	0	0	0	0	83,019	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	31,237	0	0	112,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	7,460	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	27,782	0	0	642	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	7,103	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,559	820,655	122,127	536,846	17,943,305	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	61,858	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			CAPITAL RELATED COSTS					
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	8,660	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	0	47,686	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,559	829,315	122,127	536,846	18,052,849	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	6.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	237,389	237,389				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,484,617	20,888	11,505,505			5.00
6.00	00600	MAINTENANCE & REPAIRS	1,494,333	7,524	513,215	2,015,072		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,295	88	78,558	11,695	119,636	8.00
9.00	00900	HOUSEKEEPING	205,852	6,572	240,072	21,366	1,211	9.00
10.00	01000	DIETARY	394,238	2,352	117,445	53,502	881	10.00
11.00	01100	CAFETERIA	82,199	3,701	139,321	21,187	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,101,432	9,857	543,851	32,658	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165,424	0	299,987	29,734	0	16.00
20.00	02000	NURSING PROGRAM	999,429	8,336	130,234	104,697	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,252	52,667	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	751	0	94,535	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	34,268	556	13,094	6,796	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	17,540	232	5,863	5,119	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	733	17,372	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	12,284	350	10,143	3,866	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	19,296	374	12,533	6,072	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,201,893	54,673	1,774,250	619,029	41,548	30.00
31.00	03100	INTENSIVE CARE UNIT	366,596	10,164	294,428	74,147	6,705	31.00
41.00	04100	SUBPROVIDER - IRF	90,947	3,519	92,814	33,313	6,506	41.00
43.00	04300	NURSERY	66,080	567	17,719	12,490	725	43.00
44.00	04400	SKILLED NURSING FACILITY	167,928	3,059	90,466	40,011	4,769	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,450,217	21,774	954,012	163,676	9,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,780	1,369	40,607	28,169	3,304	52.00
53.00	05300	ANESTHESIOLOGY	137,106	404	34,445	4,573	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	966,066	8,005	296,479	59,038	8,153	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	826,717	1,860	103,650	40,267	4,667	55.00
57.00	05700	CT SCAN	532,821	1,306	62,673	5,711	3,585	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	87,650	598	29,545	6,964	591	58.00
60.00	06000	LABORATORY	469,324	6,435	543,653	38,453	12	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	21,718	278	54,988	1,348	0	62.00
65.00	06500	RESPIRATORY THERAPY	351,073	5,507	160,643	6,516	0	65.00
66.00	06600	PHYSICAL THERAPY	53,490	3,128	76,250	11,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,389	1,810	43,290	5,749	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,961	551	13,350	1,947	0	68.00
69.00	06900	ELECTROCARDIOLOGY	711,563	4,893	185,627	45,375	4,752	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	117,933	1,069	31,358	6,306	36	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	175,746	695	715,720	22,987	610	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	274,525	1,305	958,707	36,461	968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	563,840	10,259	1,318,902	17,948	0	73.00
74.00	07400	RENAL DIALYSIS	3,831	0	50,980	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	49,888	1,064	37,739	0	0	88.00
90.00	09000	CLINIC	201,325	2,787	78,943	2,335	0	90.00
90.01	09001	OUTPATIENT INFUSION	47,532	869	24,996	12,252	39	90.01
90.02	04950	ONCOLOGY	11,805	384	11,041	3,043	0	90.02
91.00	09100	EMERGENCY	381,070	10,420	345,842	84,280	20,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	26,750	380	10,370	4,972	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	30,554	6,720	197,967	7,178	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	185,898	3,959	131,407	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,938,363	233,626	11,051,751	1,693,128	119,244	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,351	0	993	14,037	392	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,858	981	26,180	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	13,584	0	604	3,501	0	193.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	6.00	8.00	
193.02	19302	UNUSED SPACE	453,472	0	20,147	124,337	0	193.02
193.03	19303	HEALTH EDUCATION	0	13	316	0	0	193.03
193.04	19304	RENTED SPACE	243,531	0	10,820	179,075	0	193.04
193.05	19305	RETAIL PHARMACIES	80,649	2,769	394,694	994	0	193.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,813,808	237,389	11,505,505	2,015,072	119,636	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	475,073					9.00
10.00	01000	DIETARY	15,141	583,559				10.00
11.00	01100	CAFETERIA	5,997	0	252,405			11.00
13.00	01300	NURSING ADMINISTRATION	9,244	0	14,060	1,711,102		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,416	0	0	0	503,561	16.00
20.00	02000	NURSING PROGRAM	29,631	0	9,582	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	3,393	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,925	0	631	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	1,447	0	281	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	850	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	1,093	0	435	0	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	1,720	0	170	0	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	175,196	459,604	84,116	840,095	394,454	30.00
31.00	03100	INTENSIVE CARE UNIT	20,985	51,373	13,091	130,739	44,090	31.00
41.00	04100	SUBPROVIDER - IRF	9,429	37,489	4,841	48,341	32,177	41.00
43.00	04300	NURSERY	3,533	0	644	6,427	748	43.00
44.00	04400	SKILLED NURSING FACILITY	11,322	35,093	5,039	50,324	30,116	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,323	0	29,514	294,759	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,974	0	1,900	18,971	0	52.00
53.00	05300	ANESTHESIOLOGY	1,294	0	944	9,432	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,708	0	10,640	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,395	0	1,634	0	0	55.00
57.00	05700	CT SCAN	1,616	0	1,554	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,969	0	750	0	0	58.00
60.00	06000	LABORATORY	10,884	0	10,476	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	382	0	438	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,845	0	7,278	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,368	0	3,383	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,628	0	2,055	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	551	0	560	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,842	0	5,811	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,785	0	1,632	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,648	0	1,824	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,177	0	3,193	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,080	0	10,251	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	659	0	2,655	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	3,469	0	1,184	11,828	0	90.01
90.02	04950	ONCOLOGY	860	0	605	6,039	0	90.02
91.00	09100	EMERGENCY	23,855	0	15,824	158,040	1,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,407	0	573	5,725	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,030	0	0	82,133	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	48,249	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	469,828	583,559	251,811	1,711,102	503,561	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,971	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	573	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	993	0	0	0	0	193.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	21	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	281	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	475,073	583,559	252,405	1,711,102	503,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NURSING PROGRAM	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY		
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			20.00	21.00				22.00
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,281,909	54,919	98,679	0	57,270	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02					
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03					
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04					
23.05	02305	PARAMED ED PRGM-HIM	23.05					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
41.00	04100	SUBPROVIDER - IRF						41.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
57.00	05700	CT SCAN						57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)						58.00
60.00	06000	LABORATORY						60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
68.00	06800	SPEECH PATHOLOGY						68.00
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
74.00	07400	RENAL DIALYSIS						74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC						90.00
90.01	09001	OUTPATIENT INFUSION						90.01
90.02	04950	ONCOLOGY						90.02
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM						93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY						101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
193.00	19300	NONPAID WORKERS						193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
			NURSING PROGRAM	SERVICES-SALAR Y & FRINGES			
			20.00	21.00	22.00	23.00	23.01
193.01	19301	DENMAN SERVICES					193.01
193.02	19302	UNUSED SPACE					193.02
193.03	19303	HEALTH EDUCATION					193.03
193.04	19304	RENTED SPACE					193.04
193.05	19305	RETAIL PHARMACIES					193.05
200.00		Cross Foot Adjustments	1,281,909	54,919	98,679	0	57,270 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	1,281,909	54,919	98,679	0	57,270 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PARAMED ED PRGM-LABORATORY Y	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	
			23.02	23.03	23.04	23.05	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	30,482					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY		18,955				23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY			28,171			23.04
23.05	02305	PARAMED ED PRGM-HIM				40,165		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS					7,644,858	30.00
31.00	03100	INTENSIVE CARE UNIT					1,012,318	31.00
41.00	04100	SUBPROVIDER - IRF					359,376	41.00
43.00	04300	NURSERY					108,933	43.00
44.00	04400	SKILLED NURSING FACILITY					438,127	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM					5,969,780	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM					156,074	52.00
53.00	05300	ANESTHESIOLOGY					188,198	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC					1,365,089	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC					990,190	55.00
57.00	05700	CT SCAN					609,266	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)					128,067	58.00
60.00	06000	LABORATORY					1,079,237	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS					79,152	62.00
65.00	06500	RESPIRATORY THERAPY					532,862	65.00
66.00	06600	PHYSICAL THERAPY					151,517	66.00
67.00	06700	OCCUPATIONAL THERAPY					79,921	67.00
68.00	06800	SPEECH PATHOLOGY					25,920	68.00
69.00	06900	ELECTROCARDIOLOGY					970,863	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY					160,119	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS					924,230	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS					1,285,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS					1,926,280	73.00
74.00	07400	RENAL DIALYSIS					54,811	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC					88,691	88.00
90.00	09000	CLINIC					288,704	90.00
90.01	09001	OUTPATIENT INFUSION					102,169	90.01
90.02	04950	ONCOLOGY					33,777	90.02
91.00	09100	EMERGENCY					1,041,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM					50,177	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY					326,582	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE					369,513	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	28,542,121	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					41,744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES					89,592	192.00
193.00	19300	NONPAID WORKERS					0	193.00
193.01	19301	DENMAN SERVICES					18,682	193.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description			PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	
			23.02	23.03	23.04	23.05	24.00	
193.02	19302	UNUSED SPACE					597,956	193.02
193.03	19303	HEALTH EDUCATION					350	193.03
193.04	19304	RENTED SPACE					433,426	193.04
193.05	19305	RETAIL PHARMACIES					479,387	193.05
200.00		Cross Foot Adjustments	30,482	18,955	28,171	40,165	1,610,550	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,482	18,955	28,171	40,165	31,813,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES		1.03
1.04	00104	CAP REL COSTS-MOB PHASE I		1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL		1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST		1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER		1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
20.00	02000	NURSING PROGRAM		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		23.04
23.05	02305	PARAMED ED PRGM-HIM		23.05
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	90.01
90.02	04950	ONCOLOGY	0	90.02
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	18,682	193.01
193.02	19302	UNUSED SPACE	0	597,956	193.02
193.03	19303	HEALTH EDUCATION	0	350	193.03
193.04	19304	RENTED SPACE	0	433,426	193.04
193.05	19305	RETAIL PHARMACIES	0	479,387	193.05
200.00		Cross Foot Adjustments	0	1,610,550	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	31,813,808	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	1,092				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	121,424			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	602,329		1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	0	0	0	0	2,472	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	0	0	0	0	0	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,674	5,558	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	189	29,309	115,228	2,472	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	20,060	73,041	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,919	1,421	0	8.00
9.00	00900	HOUSEKEEPING	0	0	3,972	2,010	0	9.00
10.00	01000	DIETARY	0	0	0	15,280	0	10.00
11.00	01100	CAFETERIA	0	0	0	6,051	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,343	873	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	585	3,394	0	16.00
20.00	02000	NURSING PROGRAM	0	0	0	3,502	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	558	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	49	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	77	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	102	168,439	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	9,912	11,264	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,739	4,775	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,427	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	7,011	28,055	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	8,045	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,524	15,337	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	11,500	0	55.00
57.00	05700	CT SCAN	0	0	597	1,034	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,989	0	58.00
60.00	06000	LABORATORY	0	0	639	10,343	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,454	407	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,204	4,755	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,801	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	349	0	6,216	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	554	0	9,859	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	114	5,012	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	667	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,499	0	90.01
90.02	04950	ONCOLOGY	0	0	0	869	0	90.02
91.00	09100	EMERGENCY	0	0	5,856	15,909	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	1,420	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,092	114,488	550,560	2,472	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,212	797	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	1,000	0	193.01
193.02	19302	UNUSED SPACE	0	0	2,890	31,981	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	834	17,707	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	284	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	47,509	435,659	8,182,290	11,559	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	43.506410	3.587915	13.584420	4.675971	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
		1.05	1.06	1.07	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	61,195				1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	32,356			1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	0	0	16,978		1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP			18,033,325		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	127,755	116,074,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,761	0	2,632	8,378,669	5.00
6.00	00600	MAINTENANCE & REPAIRS	451	0	2,578	341,564	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	3,104	8.00
9.00	00900	HOUSEKEEPING	31	0	89	160,888	9.00
10.00	01000	DIETARY	0	0	0	176,784	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,111	0	0	1,017,177	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,513	0	0	55,998	16.00
20.00	02000	NURSING PROGRAM	4,076	22,323	0	151,072	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	750	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,425	0	0	7,937	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	140	764	0	5,173	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	163	892	0	6,035	23.04
23.05	02305	PARAMED ED PRGM-HIM	256	1,401	0	9,483	23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,274	6,976	0	759,455	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	154,898	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	7,536	41.00
43.00	04300	NURSERY	0	0	0	17,605	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,006	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	11,679	2,566,227	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	24,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	94,669	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	433,405	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	669,771	55.00
57.00	05700	CT SCAN	0	0	0	516,074	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	60,565	58.00
60.00	06000	LABORATORY	0	0	0	310,432	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	16,470	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	260,921	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,080	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,406	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	613,570	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	60,326	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	76,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	116,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	494,810	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,827	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	139	88.00
90.00	09000	CLINIC	0	0	0	82,929	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,305	0	0	112,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	7,452	93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,050	0	0	641	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	7,095	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,556	32,356	16,978	17,923,900	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
			1.05	1.06	1.07	2.00	4.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	61,791	479,601	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	639	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	6,581	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	47,634	1,353,917	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	829,315	122,127	536,846	18,052,849	8,870,405	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.552006	3.774478	31.620097	1.001083	0.076420	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					237,389	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.002045	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER					1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-80,226,953	258,972,410			5.00
6.00	00600	MAINTENANCE & REPAIRS	0	11,551,622	575,495		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,768,199	3,340	1,744,835	8.00
9.00	00900	HOUSEKEEPING	0	5,403,611	6,102	17,664	118,197
10.00	01000	DIETARY	0	2,643,501	15,280	12,849	3,767
11.00	01100	CAFETERIA	0	3,135,890	6,051	0	1,492
13.00	01300	NURSING ADMINISTRATION	0	12,241,171	9,327	0	2,300
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,752,208	8,492	0	2,094
20.00	02000	NURSING PROGRAM	0	2,931,346	29,901	0	7,372
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,185,456	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,127,821	0	0	0
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	294,721	1,941	0	479
23.02	02302	PARAMED ED PRGM-LABORATORY	0	131,968	1,462	0	360
23.03	02303	PARAMED ED PRGM-PHARMACY	0	391,019	0	0	0
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	228,301	1,104	0	272
23.05	02305	PARAMED ED PRGM-HIM	0	282,096	1,734	0	428
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	39,938,107	176,791	605,948	43,588
31.00	03100	INTENSIVE CARE UNIT	0	6,627,082	21,176	97,789	5,221
41.00	04100	SUBPROVIDER - IRF	0	2,089,091	9,514	94,880	2,346
43.00	04300	NURSERY	0	398,823	3,567	10,579	879
44.00	04400	SKILLED NURSING FACILITY	0	2,036,231	11,427	69,559	2,817
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	21,473,223	46,745	138,626	11,525
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	913,995	8,045	48,192	1,984
53.00	05300	ANESTHESIOLOGY	0	775,300	1,306	0	322
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,673,257	16,861	118,907	4,157
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,332,994	11,500	68,064	2,835
57.00	05700	CT SCAN	0	1,410,668	1,631	52,283	402
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	665,006	1,989	8,625	490
60.00	06000	LABORATORY	0	12,236,725	10,982	172	2,708
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,237,683	385	0	95
65.00	06500	RESPIRATORY THERAPY	0	3,615,811	1,861	0	459
66.00	06600	PHYSICAL THERAPY	0	1,716,254	3,398	0	838
67.00	06700	OCCUPATIONAL THERAPY	0	974,394	1,642	0	405
68.00	06800	SPEECH PATHOLOGY	0	300,494	556	0	137
69.00	06900	ELECTROCARDIOLOGY	0	4,178,164	12,959	69,306	3,195
70.00	07000	ELECTROENCEPHALOGRAPHY	0	705,812	1,801	528	444
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,109,662	6,565	8,898	1,654
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,578,900	10,413	14,113	2,532
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,686,282	5,126	0	1,264
74.00	07400	RENAL DIALYSIS	0	1,147,473	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	849,447	0	0	0
90.00	09000	CLINIC	0	1,776,885	667	0	164
90.01	09001	OUTPATIENT INFUSION	0	562,629	3,499	574	863
90.02	04950	ONCOLOGY	0	248,509	869	0	214
91.00	09100	EMERGENCY	0	7,784,314	24,070	301,562	5,935
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	233,406	1,420	0	350
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	4,455,901	2,050	0	505
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0				
116.00	11600	HOSPICE	0	2,957,745	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-80,226,953	248,759,197	483,549	1,739,118	116,892
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,351	4,009	5,717	988
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	589,273	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	6.00	8.00	9.00	
193.01	19301	DENMAN SERVICES	0	13,584	1,000	0	247	193.01
193.02	19302	UNUSED SPACE	0	453,472	35,510	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	7,104	0	0	0	193.03
193.04	19304	RENTED SPACE	0	243,531	51,143	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	8,883,898	284	0	70	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		80,226,953	15,130,199	2,403,780	7,262,357	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.309790	26.290757	1.377655	61.442820	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		11,505,505	2,015,072	119,636	475,073	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.044428	3.501459	0.068566	4.019332	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING PROGRAM (ASSIGNED TIME)	
			10.00	11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	241,023					10.00
11.00	01100	CAFETERIA	0	363,539				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,251	1,889,695			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	172,242		16.00
20.00	02000	NURSING PROGRAM	0	13,801	0	0	28,643	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,887	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	909	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	405	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	1,224	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	626	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	0	245	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	189,827	121,152	927,778	134,922	22,108	30.00
31.00	03100	INTENSIVE CARE UNIT	21,218	18,855	144,385	15,081	863	31.00
41.00	04100	SUBPROVIDER - IRF	15,484	6,972	53,387	11,006	1,635	41.00
43.00	04300	NURSERY	0	927	7,098	256	392	43.00
44.00	04400	SKILLED NURSING FACILITY	14,494	7,258	55,577	10,301	8	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	42,509	325,524	0	865	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,736	20,951	0	1,146	52.00
53.00	05300	ANESTHESIOLOGY	0	1,360	10,416	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,325	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,354	0	0	0	55.00
57.00	05700	CT SCAN	0	2,238	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,080	0	0	0	58.00
60.00	06000	LABORATORY	0	15,088	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	631	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	10,483	0	0	8	65.00
66.00	06600	PHYSICAL THERAPY	0	4,872	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,960	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	806	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,369	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,351	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,627	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,599	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,764	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	3,824	0	0	36	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,706	13,062	0	210	90.01
90.02	04950	ONCOLOGY	0	871	6,669	0	8	90.02
91.00	09100	EMERGENCY	0	22,792	174,535	676	1,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	826	6,323	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	90,705	0	204	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	53,285	0	19	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,023	362,683	1,889,695	172,242	28,528	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	826	0	0	115	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING PROGRAM (ASSIGNED TIME)	
			10.00	11.00	13.00	16.00	20.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	30	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,113,310	4,358,115	16,662,665	9,195,897	5,243,971	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.066048	11.988026	8.817648	53.389400	183.080369	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	583,559	252,405	1,711,102	503,561	1,281,909	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.421176	0.694300	0.905491	2.923567	44.754704	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
		21.00	22.00	23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER					1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING PROGRAM					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	20,580				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		20,580			22.00
23.00	02300	PARAMED ED PRGM			0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				100	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY				100	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY					23.04
23.05	02305	PARAMED ED PRGM-HIM					23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,948	14,948	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	904	904	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	500	500	0	0	41.00
43.00	04300	NURSERY	517	517	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	742	742	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48	48	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48	48	0	100	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	194	194	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	371	371	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	581	581	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,727	1,727	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,580	20,580	0	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
			SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00	23.00	23.01	23.02	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,552,698	2,845,584	0	477,381	238,261	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	75.446939	138.269388	0.000000	4,773.810000	2,382.610000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,919	98,679	0	57,270	30,482	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.668562	4.794898	0.000000	572.700000	304.820000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000	0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.03	23.04	23.05	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES				1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES				1.03
1.04	00104	CAP REL COSTS-MOB PHASE I				1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL				1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST				1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER				1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
20.00	02000	NURSING PROGRAM				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	100			23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		100		23.04
23.05	02305	PARAMED ED PRGM-HIM			172,242	23.05
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	134,922	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	15,081	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	11,006	41.00
43.00	04300	NURSERY	0	0	256	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	10,301	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	100	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	172,242	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet B-1
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.03	23.04	23.05	
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	193.04
193.05	19305	RETAIL PHARMACIES	0	0	0	193.05
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	526,826	352,268	444,310	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,268.260000	3,522.680000	2.579568	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,955	28,171	40,165	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	189.550000	281.710000	0.233189	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

			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	84,943,124		84,943,124	40,266	84,983,390
31.00	03100	INTENSIVE CARE UNIT	12,555,675		12,555,675	23,658	12,579,333
41.00	04100	SUBPROVIDER - IRF	4,995,169		4,995,169	6,715	5,001,884
43.00	04300	NURSERY	844,532		844,532	0	844,532
44.00	04400	SKILLED NURSING FACILITY	4,638,794		4,638,794	0	4,638,794
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,791,802		33,791,802	14,896	33,806,698
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,024,294		2,024,294	0	2,024,294
53.00	05300	ANESTHESIOLOGY	1,177,750		1,177,750	0	1,177,750
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,264,181		10,264,181	0	10,264,181
55.00	05500	RADIOLOGY-THERAPEUTIC	3,654,255		3,654,255	0	3,654,255
57.00	05700	CT SCAN	2,014,116		2,014,116	0	2,014,116
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	978,246		978,246	0	978,246
60.00	06000	LABORATORY	16,902,025		16,902,025	0	16,902,025
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,644,628		1,644,628	0	1,644,628
65.00	06500	RESPIRATORY THERAPY	5,292,485	0	5,292,485	4,226	5,296,711
66.00	06600	PHYSICAL THERAPY	2,447,163	0	2,447,163	0	2,447,163
67.00	06700	OCCUPATIONAL THERAPY	1,379,790	0	1,379,790	0	1,379,790
68.00	06800	SPEECH PATHOLOGY	426,282	0	426,282	0	426,282
69.00	06900	ELECTROCARDIOLOGY	6,205,337		6,205,337	8,878	6,214,215
70.00	07000	ELECTROENCEPHALOGRAPHY	1,028,007		1,028,007	2,196	1,030,203
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,418,250		21,418,250	0	21,418,250
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,767,742		28,767,742	0	28,767,742
73.00	07300	DRUGS CHARGED TO PATIENTS	39,799,042		39,799,042	0	39,799,042
74.00	07400	RENAL DIALYSIS	1,502,949		1,502,949	0	1,502,949
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,112,597		1,112,597	0	1,112,597
90.00	09000	CLINIC	2,407,392		2,407,392	1,074	2,408,466
90.01	09001	OUTPATIENT INFUSION	1,056,808		1,056,808	0	1,056,808
90.02	04950	ONCOLOGY	432,203		432,203	0	432,203
91.00	09100	EMERGENCY	13,646,641		13,646,641	109,505	13,756,146
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,558,592		8,558,592	0	8,558,592
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	430,207		430,207	0	430,207
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	6,758,373		6,758,373		6,758,373
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	4,347,352		4,347,352		4,347,352
200.00		Subtotal (see instructions)	327,445,803	0	327,445,803	211,414	327,657,217
201.00		Less Observation Beds	8,558,592		8,558,592		8,558,592
202.00		Total (see instructions)	318,887,211	0	318,887,211	211,414	319,098,625

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
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			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	157,094,600		157,094,600		30.00
31.00	03100	INTENSIVE CARE UNIT	65,385,957		65,385,957		31.00
41.00	04100	SUBPROVIDER - IRF	7,940,668		7,940,668		41.00
43.00	04300	NURSERY	3,266,816		3,266,816		43.00
44.00	04400	SKILLED NURSING FACILITY	5,719,927		5,719,927		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,550,272	128,194,025	181,744,297	0.185930	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,979,589	786,817	9,766,406	0.207271	0.000000
53.00	05300	ANESTHESIOLOGY	17,297,476	32,040,789	49,338,265	0.023871	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,602,472	42,674,981	63,277,453	0.162209	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	586,447	12,834,679	13,421,126	0.272276	0.000000
57.00	05700	CT SCAN	47,225,987	61,999,553	109,225,540	0.018440	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,492,632	12,586,845	26,079,477	0.037510	0.000000
60.00	06000	LABORATORY	102,208,923	102,242,052	204,450,975	0.082670	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,932,019	2,769,326	8,701,345	0.189008	0.000000
65.00	06500	RESPIRATORY THERAPY	23,703,569	5,377,908	29,081,477	0.181988	0.000000
66.00	06600	PHYSICAL THERAPY	5,318,259	686,657	6,004,916	0.407527	0.000000
67.00	06700	OCCUPATIONAL THERAPY	4,508,789	302,543	4,811,332	0.286779	0.000000
68.00	06800	SPEECH PATHOLOGY	1,438,695	453,379	1,892,074	0.225299	0.000000
69.00	06900	ELECTROCARDIOLOGY	54,895,411	81,508,790	136,404,201	0.045492	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	833,011	3,695,789	4,528,800	0.226993	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,334,655	89,171,573	157,506,228	0.135984	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,674,708	83,659,040	127,333,748	0.225924	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	157,758,411	163,625,527	321,383,938	0.123836	0.000000
74.00	07400	RENAL DIALYSIS	3,981,224	0	3,981,224	0.377509	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,617,304	1,617,304		88.00
90.00	09000	CLINIC	13,011	2,671,893	2,684,904	0.896640	0.000000
90.01	09001	OUTPATIENT INFUSION	21,204	2,706,308	2,727,512	0.387462	0.000000
90.02	04950	ONCOLOGY	4,348	1,076,939	1,081,287	0.399712	0.000000
91.00	09100	EMERGENCY	21,470,380	39,797,887	61,268,267	0.222736	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,154,222	14,369,646	17,523,868	0.488396	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,952	667,025	669,977	0.642122	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	7,737,387	7,737,387		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	405,415	5,676,571	6,081,986		116.00
200.00		Subtotal (see instructions)	898,802,049	900,931,233	1,799,733,282		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	898,802,049	900,931,233	1,799,733,282		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/28/2022 2:09 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.186012		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207271		52.00
53.00	05300	ANESTHESIOLOGY	0.023871		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162209		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272276		55.00
57.00	05700	CT SCAN	0.018440		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.037510		58.00
60.00	06000	LABORATORY	0.082670		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.189008		62.00
65.00	06500	RESPIRATORY THERAPY	0.182133		65.00
66.00	06600	PHYSICAL THERAPY	0.407527		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.286779		67.00
68.00	06800	SPEECH PATHOLOGY	0.225299		68.00
69.00	06900	ELECTROCARDIOLOGY	0.045557		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.227478		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.135984		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225924		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123836		73.00
74.00	07400	RENAL DIALYSIS	0.377509		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.897040		90.00
90.01	09001	OUTPATIENT INFUSION	0.387462		90.01
90.02	04950	ONCOLOGY	0.399712		90.02
91.00	09100	EMERGENCY	0.224523		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488396		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.642122		93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,943,124		84,943,124	40,266	84,983,390	30.00
31.00	03100	INTENSIVE CARE UNIT	12,555,675		12,555,675	23,658	12,579,333	31.00
41.00	04100	SUBPROVIDER - IRF	4,995,169		4,995,169	6,715	5,001,884	41.00
43.00	04300	NURSERY	844,532		844,532	0	844,532	43.00
44.00	04400	SKILLED NURSING FACILITY	4,638,794		4,638,794	0	4,638,794	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,791,802		33,791,802	14,896	33,806,698	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,024,294		2,024,294	0	2,024,294	52.00
53.00	05300	ANESTHESIOLOGY	1,177,750		1,177,750	0	1,177,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,264,181		10,264,181	0	10,264,181	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,654,255		3,654,255	0	3,654,255	55.00
57.00	05700	CT SCAN	2,014,116		2,014,116	0	2,014,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	978,246		978,246	0	978,246	58.00
60.00	06000	LABORATORY	16,902,025		16,902,025	0	16,902,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,644,628		1,644,628	0	1,644,628	62.00
65.00	06500	RESPIRATORY THERAPY	5,292,485	0	5,292,485	4,226	5,296,711	65.00
66.00	06600	PHYSICAL THERAPY	2,447,163	0	2,447,163	0	2,447,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,379,790	0	1,379,790	0	1,379,790	67.00
68.00	06800	SPEECH PATHOLOGY	426,282	0	426,282	0	426,282	68.00
69.00	06900	ELECTROCARDIOLOGY	6,205,337		6,205,337	8,878	6,214,215	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,028,007		1,028,007	2,196	1,030,203	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,418,250		21,418,250	0	21,418,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,767,742		28,767,742	0	28,767,742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,799,042		39,799,042	0	39,799,042	73.00
74.00	07400	RENAL DIALYSIS	1,502,949		1,502,949	0	1,502,949	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,112,597		1,112,597	0	1,112,597	88.00
90.00	09000	CLINIC	2,407,392		2,407,392	1,074	2,408,466	90.00
90.01	09001	OUTPATIENT INFUSION	1,056,808		1,056,808	0	1,056,808	90.01
90.02	04950	ONCOLOGY	432,203		432,203	0	432,203	90.02
91.00	09100	EMERGENCY	13,646,641		13,646,641	109,505	13,756,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,558,592		8,558,592	0	8,558,592	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	430,207		430,207	0	430,207	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,758,373		6,758,373		6,758,373	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,347,352		4,347,352		4,347,352	116.00
200.00		Subtotal (see instructions)	327,445,803	0	327,445,803	211,414	327,657,217	200.00
201.00		Less Observation Beds	8,558,592		8,558,592		8,558,592	201.00
202.00		Total (see instructions)	318,887,211	0	318,887,211	211,414	319,098,625	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	157,094,600		157,094,600		30.00
31.00	03100	INTENSIVE CARE UNIT	65,385,957		65,385,957		31.00
41.00	04100	SUBPROVIDER - IRF	7,940,668		7,940,668		41.00
43.00	04300	NURSERY	3,266,816		3,266,816		43.00
44.00	04400	SKILLED NURSING FACILITY	5,719,927		5,719,927		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,550,272	128,194,025	181,744,297	0.185930	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,979,589	786,817	9,766,406	0.207271	0.000000
53.00	05300	ANESTHESIOLOGY	17,297,476	32,040,789	49,338,265	0.023871	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,602,472	42,674,981	63,277,453	0.162209	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	586,447	12,834,679	13,421,126	0.272276	0.000000
57.00	05700	CT SCAN	47,225,987	61,999,553	109,225,540	0.018440	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,492,632	12,586,845	26,079,477	0.037510	0.000000
60.00	06000	LABORATORY	102,208,923	102,242,052	204,450,975	0.082670	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,932,019	2,769,326	8,701,345	0.189008	0.000000
65.00	06500	RESPIRATORY THERAPY	23,703,569	5,377,908	29,081,477	0.181988	0.000000
66.00	06600	PHYSICAL THERAPY	5,318,259	686,657	6,004,916	0.407527	0.000000
67.00	06700	OCCUPATIONAL THERAPY	4,508,789	302,543	4,811,332	0.286779	0.000000
68.00	06800	SPEECH PATHOLOGY	1,438,695	453,379	1,892,074	0.225299	0.000000
69.00	06900	ELECTROCARDIOLOGY	54,895,411	81,508,790	136,404,201	0.045492	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	833,011	3,695,789	4,528,800	0.226993	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,334,655	89,171,573	157,506,228	0.135984	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,674,708	83,659,040	127,333,748	0.225924	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	157,758,411	163,625,527	321,383,938	0.123836	0.000000
74.00	07400	RENAL DIALYSIS	3,981,224	0	3,981,224	0.377509	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,617,304	1,617,304	0.687933	0.000000
90.00	09000	CLINIC	13,011	2,671,893	2,684,904	0.896640	0.000000
90.01	09001	OUTPATIENT INFUSION	21,204	2,706,308	2,727,512	0.387462	0.000000
90.02	04950	ONCOLOGY	4,348	1,076,939	1,081,287	0.399712	0.000000
91.00	09100	EMERGENCY	21,470,380	39,797,887	61,268,267	0.222736	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,154,222	14,369,646	17,523,868	0.488396	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,952	667,025	669,977	0.642122	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	7,737,387	7,737,387		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	405,415	5,676,571	6,081,986		116.00
200.00		Subtotal (see instructions)	898,802,049	900,931,233	1,799,733,282		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	898,802,049	900,931,233	1,799,733,282		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	OUTPATIENT INFUSION	0.000000			90.01
90.02	04950	ONCOLOGY	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,644,858	0	7,644,858	64,205	119.07	30.00	
31.00	INTENSIVE CARE UNIT	1,012,318		1,012,318	6,583	153.78	31.00	
41.00	SUBPROVIDER - IRF	359,376	0	359,376	4,772	75.31	41.00	
43.00	NURSERY	108,933		108,933	1,737	62.71	43.00	
44.00	SKILLED NURSING FACILITY	438,127		438,127	4,428	98.94	44.00	
200.00	Total (lines 30 through 199)	9,563,612		9,563,612	81,725		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	26,325	3,134,518					30.00
31.00	INTENSIVE CARE UNIT	2,940	452,113					31.00
41.00	SUBPROVIDER - IRF	3,067	230,976					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	2,972	294,050					44.00
200.00	Total (lines 30 through 199)	35,304	4,111,657					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description			Title XVIII		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	5,969,780	181,744,297	0.032847	24,181,428	794,287
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,074	9,766,406	0.015981	33,399	534
53.00	05300	ANESTHESIOLOGY	188,198	49,338,265	0.003814	7,314,446	27,897
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,365,089	63,277,453	0.021573	10,761,028	232,148
55.00	05500	RADIOLOGY-THERAPEUTIC	990,190	13,421,126	0.073778	342,082	25,238
57.00	05700	CT SCAN	609,266	109,225,540	0.005578	23,358,728	130,295
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,067	26,079,477	0.004911	6,506,701	31,954
60.00	06000	LABORATORY	1,079,237	204,450,975	0.005279	50,057,166	264,252
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,152	8,701,345	0.009097	2,872,052	26,127
65.00	06500	RESPIRATORY THERAPY	532,862	29,081,477	0.018323	12,284,447	225,088
66.00	06600	PHYSICAL THERAPY	151,517	6,004,916	0.025232	1,503,588	37,939
67.00	06700	OCCUPATIONAL THERAPY	79,921	4,811,332	0.016611	1,037,619	17,236
68.00	06800	SPEECH PATHOLOGY	25,920	1,892,074	0.013699	507,784	6,956
69.00	06900	ELECTROCARDIOLOGY	970,863	136,404,201	0.007118	28,089,373	199,940
70.00	07000	ELECTROENCEPHALOGRAPHY	160,119	4,528,800	0.035356	451,915	15,978
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	924,230	157,506,228	0.005868	30,320,158	177,919
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,285,336	127,333,748	0.010094	25,185,409	254,222
73.00	07300	DRUGS CHARGED TO PATIENTS	1,926,280	321,383,938	0.005994	74,282,863	445,251
74.00	07400	RENAL DIALYSIS	54,811	3,981,224	0.013767	1,471,742	20,261
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	88,691	1,617,304	0.054839	0	0
90.00	09000	CLINIC	288,704	2,684,904	0.107529	2,484	267
90.01	09001	OUTPATIENT INFUSION	102,169	2,727,512	0.037459	18,954	710
90.02	04950	ONCOLOGY	33,777	1,081,287	0.031238	0	0
91.00	09100	EMERGENCY	1,041,984	61,268,267	0.017007	10,040,750	170,763
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	769,905	17,523,868	0.043935	968,244	42,540
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	50,177	669,977	0.074894	0	0
200.00		Total (lines 50 through 199)	19,052,319	1,546,505,941		311,592,360	3,147,802

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/28/2022 2:09 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	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	4,047,540		0	348,041		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	157,998		0	38,902		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	299,336		0	28,391		0	41.00
43.00	04300	NURSERY		0	71,768		0	660		0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	1,465		0	26,572		0	44.00
200.00		Total (lines 30 through 199)		0	4,578,107		0	442,566		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	4,395,581		64,205	68.46		26,325	30.00
31.00	03100	INTENSIVE CARE UNIT			196,900		6,583	29.91		2,940	31.00
41.00	04100	SUBPROVIDER - IRF		0	327,727		4,772	68.68		3,067	41.00
43.00	04300	NURSERY			72,428		1,737	41.70		0	43.00
44.00	04400	SKILLED NURSING FACILITY			28,037		4,428	6.33		2,972	44.00
200.00		Total (lines 30 through 199)			5,020,673		81,725			35,304	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			1,802,210						30.00
31.00	03100	INTENSIVE CARE UNIT			87,935						31.00
41.00	04100	SUBPROVIDER - IRF			210,642						41.00
43.00	04300	NURSERY			0						43.00
44.00	04400	SKILLED NURSING FACILITY			18,813						44.00
200.00		Total (lines 30 through 199)			2,119,600						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 2:09 pm

			Title XVIII		Hospital		PPS	
	Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	158,365	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	209,810	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	477,381	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	238,261	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,465	0	352,268	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	526,826	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	6,591	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	38,447	0	0	90.01
90.02	04950	ONCOLOGY	0	0	1,465	0	0	90.02
91.00	09100	EMERGENCY	0	0	187,840	0	1,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	407,620	0	35,047	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	1,011,603	0	1,631,527	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 2:09 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	158,365	158,365	181,744,297	0.000871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	209,810	209,810	9,766,406	0.021483	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	49,338,265	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	477,381	477,381	63,277,453	0.007544	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,421,126	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	109,225,540	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	26,079,477	0.000000	58.00
60.00	06000	LABORATORY	0	238,261	238,261	204,450,975	0.001165	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,701,345	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	353,733	353,733	29,081,477	0.012164	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,004,916	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,811,332	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,892,074	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	136,404,201	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,528,800	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	157,506,228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	127,333,748	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	526,826	526,826	321,383,938	0.001639	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,981,224	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,617,304	0.000000	88.00
90.00	09000	CLINIC	0	6,591	6,591	2,684,904	0.002455	90.00
90.01	09001	OUTPATIENT INFUSION	0	38,447	38,447	2,727,512	0.014096	90.01
90.02	04950	ONCOLOGY	0	1,465	1,465	1,081,287	0.001355	90.02
91.00	09100	EMERGENCY	0	189,584	189,584	61,268,267	0.003094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	442,667	442,667	17,523,868	0.025261	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	669,977	0.000000	93.99
200.00		Total (lines 50 through 199)	0	2,643,130	2,643,130	1,546,505,941		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 2:09 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000871	24,181,428	21,062	41,445,345	36,099	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.021483	33,399	718	1,766	38	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	7,314,446	0	9,581,821	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007544	10,761,028	81,181	12,092,613	91,227	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	342,082	0	7,465,994	0	55.00
57.00	05700	CT SCAN	0.000000	23,358,728	0	16,377,150	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	6,506,701	0	3,486,598	0	58.00
60.00	06000	LABORATORY	0.001165	50,057,166	58,317	11,781,116	13,725	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,872,052	0	1,039,260	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.012164	12,284,447	149,428	2,388,735	29,057	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,503,588	0	29,752	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,037,619	0	16,076	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	507,784	0	15,566	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	28,089,373	0	36,582,337	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	451,915	0	971,348	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	30,320,158	0	31,864,223	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	25,185,409	0	33,154,929	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001639	74,282,863	121,750	62,823,752	102,968	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,471,742	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.002455	2,484	6	788,736	1,936	90.00
90.01	09001	OUTPATIENT INFUSION	0.014096	18,954	267	1,216,496	17,148	90.01
90.02	04950	ONCOLOGY	0.001355	0	0	985,919	1,336	90.02
91.00	09100	EMERGENCY	0.003094	10,040,750	31,066	8,008,957	24,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.025261	968,244	24,459	4,738,619	119,702	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		311,592,360	488,254	286,857,108	438,016	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 2/28/2022 2:09 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.185930	41,445,345	0	0	7,705,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.207271	1,766	0	0	366	52.00
53.00	05300	ANESTHESIOLOGY		0.023871	9,581,821	0	0	228,728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.162209	12,092,613	0	0	1,961,531	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.272276	7,465,994	0	0	2,032,811	55.00
57.00	05700	CT SCAN		0.018440	16,377,150	0	0	301,995	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.037510	3,486,598	0	0	130,782	58.00
60.00	06000	LABORATORY		0.082670	11,781,116	984	0	973,945	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.189008	1,039,260	0	0	196,428	62.00
65.00	06500	RESPIRATORY THERAPY		0.181988	2,388,735	0	0	434,721	65.00
66.00	06600	PHYSICAL THERAPY		0.407527	29,752	0	0	12,125	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.286779	16,076	0	0	4,610	67.00
68.00	06800	SPEECH PATHOLOGY		0.225299	15,566	0	0	3,507	68.00
69.00	06900	ELECTROCARDIOLOGY		0.045492	36,582,337	0	0	1,664,204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.226993	971,348	0	0	220,489	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.135984	31,864,223	0	0	4,333,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.225924	33,154,929	359,369	0	7,490,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.123836	62,823,752	0	0	7,779,842	73.00
74.00	07400	RENAL DIALYSIS		0.377509	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC		0.896640	788,736	0	0	707,212	90.00
90.01	09001	OUTPATIENT INFUSION		0.387462	1,216,496	0	0	471,346	90.01
90.02	04950	ONCOLOGY		0.399712	985,919	0	0	394,084	90.02
91.00	09100	EMERGENCY		0.222736	8,008,957	0	0	1,783,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.488396	4,738,619	0	0	2,314,323	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.642122	0	0	0	0	93.99
200.00		Subtotal (see instructions)			286,857,108	360,353	0	41,146,384	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			286,857,108	360,353	0	41,146,384	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 2:09 pm

			Title XVIII	Hospital	PPS
	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	81	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,190	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
90.02	04950	ONCOLOGY	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	81,271	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	81,271	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part II Date/Time Prepared: 2/28/2022 2:09 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,969,780	181,744,297	0.032847	70,753	2,324		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,074	9,766,406	0.015981	0	0		52.00
53.00	05300	ANESTHESIOLOGY	188,198	49,338,265	0.003814	6,809	26		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,365,089	63,277,453	0.021573	130,166	2,808		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	990,190	13,421,126	0.073778	52,304	3,859		55.00
57.00	05700	CT SCAN	609,266	109,225,540	0.005578	110,087	614		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,067	26,079,477	0.004911	85,018	418		58.00
60.00	06000	LABORATORY	1,079,237	204,450,975	0.005279	979,655	5,172		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,152	8,701,345	0.009097	57,042	519		62.00
65.00	06500	RESPIRATORY THERAPY	532,862	29,081,477	0.018323	272,029	4,984		65.00
66.00	06600	PHYSICAL THERAPY	151,517	6,004,916	0.025232	1,262,746	31,862		66.00
67.00	06700	OCCUPATIONAL THERAPY	79,921	4,811,332	0.016611	1,211,635	20,126		67.00
68.00	06800	SPEECH PATHOLOGY	25,920	1,892,074	0.013699	310,344	4,251		68.00
69.00	06900	ELECTROCARDIOLOGY	970,863	136,404,201	0.007118	81,118	577		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,119	4,528,800	0.035356	7,161	253		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	924,230	157,506,228	0.005868	116,402	683		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,285,336	127,333,748	0.010094	39,609	400		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,926,280	321,383,938	0.005994	1,400,553	8,395		73.00
74.00	07400	RENAL DIALYSIS	54,811	3,981,224	0.013767	104,401	1,437		74.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	88,691	1,617,304	0.054839	0	0		88.00
90.00	09000	CLINIC	288,704	2,684,904	0.107529	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	102,169	2,727,512	0.037459	0	0		90.01
90.02	04950	ONCOLOGY	33,777	1,081,287	0.031238	0	0		90.02
91.00	09100	EMERGENCY	1,041,984	61,268,267	0.017007	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	17,523,868	0.000000	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	50,177	669,977	0.074894	0	0		93.99
200.00		Total (lines 50 through 199)	18,282,414	1,546,505,941		6,297,832	88,708		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015

Component CCN: 14-T015

Period:
From 10/01/2020
To 09/30/2021

Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 2:09 pm

				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	158,365	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	209,810	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	477,381	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	238,261	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,465	0	352,268	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	526,826	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	6,591	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	38,447	0	0	90.01
90.02	04950	ONCOLOGY	0	0	1,465	0	0	90.02
91.00	09100	EMERGENCY	0	0	187,840	0	1,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	603,983	0	1,596,480	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 2:09 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	158,365	158,365	181,744,297	0.000871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	209,810	209,810	9,766,406	0.021483	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	49,338,265	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	477,381	477,381	63,277,453	0.007544	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,421,126	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	109,225,540	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	26,079,477	0.000000	58.00
60.00	06000	LABORATORY	0	238,261	238,261	204,450,975	0.001165	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,701,345	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	353,733	353,733	29,081,477	0.012164	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,004,916	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,811,332	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,892,074	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	136,404,201	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,528,800	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	157,506,228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	127,333,748	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	526,826	526,826	321,383,938	0.001639	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,981,224	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,617,304	0.000000	88.00
90.00	09000	CLINIC	0	6,591	6,591	2,684,904	0.002455	90.00
90.01	09001	OUTPATIENT INFUSION	0	38,447	38,447	2,727,512	0.014096	90.01
90.02	04950	ONCOLOGY	0	1,465	1,465	1,081,287	0.001355	90.02
91.00	09100	EMERGENCY	0	189,584	189,584	61,268,267	0.003094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	17,523,868	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	669,977	0.000000	93.99
200.00		Total (lines 50 through 199)	0	2,200,463	2,200,463	1,546,505,941		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 2:09 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000871	70,753	62	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.021483	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	6,809	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.007544	130,166	982	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	52,304	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	110,087	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	85,018	0	0	0	58.00
60.00	06000	LABORATORY		0.001165	979,655	1,141	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	57,042	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.012164	272,029	3,309	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,262,746	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,211,635	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	310,344	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	81,118	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	7,161	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	116,402	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	39,609	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.001639	1,400,553	2,296	200	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	104,401	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
90.00	09000	CLINIC		0.002455	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0.014096	0	0	0	0	90.01
90.02	04950	ONCOLOGY		0.001355	0	0	0	0	90.02
91.00	09100	EMERGENCY		0.003094	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			6,297,832	7,790	200	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-T015

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 2:09 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.185930	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207271	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.023871	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162209	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.272276	0	0	0	0 55.00
57.00	05700 CT SCAN	0.018440	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.037510	0	0	0	0 58.00
60.00	06000 LABORATORY	0.082670	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.189008	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.181988	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.407527	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286779	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.225299	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.045492	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.226993	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.135984	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.225924	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.123836	200	0	2,994	25 73.00
74.00	07400 RENAL DIALYSIS	0.377509	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC					88.00
90.00	09000 CLINIC	0.896640	0	0	0	0 90.00
90.01	09001 OUTPATIENT INFUSION	0.387462	0	0	0	0 90.01
90.02	04950 ONCOLOGY	0.399712	0	0	0	0 90.02
91.00	09100 EMERGENCY	0.222736	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.488396	0	0	0	0 92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.642122	0	0	0	0 93.99
200.00	Subtotal (see instructions)		200	0	2,994	25 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		200	0	2,994	25 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-T015

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 2:09 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Costs		
			Cost	Cost	
			Reimbursed	Reimbursed	
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	371	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
90.02	04950	ONCOLOGY	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	371	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	371	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 2:09 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	158,365	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	209,810	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	477,381	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	238,261	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,465	0	352,268	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	526,826	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	6,591	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	38,447	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	1,465	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	187,840	0	1,744	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	603,983	0	1,596,480	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 2:09 pm	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	158,365	158,365	181,744,297	0.000871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	209,810	209,810	9,766,406	0.021483	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	49,338,265	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	477,381	477,381	63,277,453	0.007544	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,421,126	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	109,225,540	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	26,079,477	0.000000	58.00
60.00	06000	LABORATORY	0	238,261	238,261	204,450,975	0.001165	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,701,345	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	353,733	353,733	29,081,477	0.012164	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,004,916	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,811,332	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,892,074	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	136,404,201	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,528,800	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	157,506,228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	127,333,748	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	526,826	526,826	321,383,938	0.001639	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,981,224	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,617,304	0.000000	88.00
90.00	09000	CLINIC	0	6,591	6,591	2,684,904	0.002455	90.00
90.01	09001	OUTPATIENT INFUSION	0	38,447	38,447	2,727,512	0.014096	90.01
90.02	04950	ONCOLOGY	0	1,465	1,465	1,081,287	0.001355	90.02
91.00	09100	EMERGENCY	0	189,584	189,584	61,268,267	0.003094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	17,523,868	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	669,977	0.000000	93.99
200.00		Total (lines 50 through 199)	0	2,200,463	2,200,463	1,546,505,941		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 2:09 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000871	66,173	58	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.021483	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.007544	156,271	1,179	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.001165	1,114,802	1,299	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	71,540	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.012164	455,039	5,535	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	570,512	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	594,099	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	38,285	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	47,646	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	5,124	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	126,605	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		0.001639	1,992,963	3,266	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	104,401	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
90.00	09000	CLINIC		0.002455	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0.014096	0	0	0	0	90.01
90.02	04950	ONCOLOGY		0.001355	0	0	0	0	90.02
91.00	09100	EMERGENCY		0.003094	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			5,343,460	11,337	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-5643

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 2:09 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.185930	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207271	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.023871	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162209	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.272276	0	0	0	0 55.00
57.00	05700 CT SCAN	0.018440	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.037510	0	0	0	0 58.00
60.00	06000 LABORATORY	0.082670	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.189008	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.181988	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.407527	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286779	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.225299	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.045492	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.226993	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.135984	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.225924	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.123836	0	0	23,809	0 73.00
74.00	07400 RENAL DIALYSIS	0.377509	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC					88.00
90.00	09000 CLINIC	0.896640	0	0	0	0 90.00
90.01	09001 OUTPATIENT INFUSION	0.387462	0	0	0	0 90.01
90.02	04950 ONCOLOGY	0.399712	0	0	0	0 90.02
91.00	09100 EMERGENCY	0.222736	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.488396	0	0	0	0 92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.642122	0	0	0	0 93.99
200.00	Subtotal (see instructions)		0	0	23,809	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	23,809	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-5643

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 2:09 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,948	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
90.02	04950	ONCOLOGY	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	2,948	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	2,948	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		64,205	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		64,205	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)		57,739	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)		26,325	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)		84,983,390	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)		84,983,390	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)		84,983,390	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)		1,323.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		34,844,560	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)		34,844,560	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	12,579,333	6,583	1,910.88	2,940	5,617,987
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					38,823,072
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					79,285,619
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,476,776
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,636,056
52.00	Total Program excludable cost (sum of lines 50 and 51)					9,112,832
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					70,172,787
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					6,466
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,323.63
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,558,592

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 2:09 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	7,644,858	84,983,390	0.089957	8,558,592	769,905	90.00
91.00 Nursing Program cost	4,047,540	84,983,390	0.047627	8,558,592	407,620	91.00
92.00 Allied health cost	348,041	84,983,390	0.004095	8,558,592	35,047	92.00
93.00 All other Medical Education	0	84,983,390	0.000000	8,558,592	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,772	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,772	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,772	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,067	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)		5,001,884	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)		5,001,884	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)		5,001,884	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)		1,048.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,214,737	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,214,737	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm	
				Title XVIII		Subprovider - IRF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,370,159	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,584,896	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)					441,618	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					96,498	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					538,116	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,046,780	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	359,376	5,001,884	0.071848	0	0	90.00
91.00	Nursing Program cost	299,336	5,001,884	0.059845	0	0	91.00
92.00	Allied health cost	28,391	5,001,884	0.005676	0	0	92.00
93.00	All other Medical Education	0	5,001,884	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,428	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,428	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,428	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,972	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,638,794	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,638,794	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,638,794	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				4,638,794	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				1,047.60	71.00
72.00 Program routine service cost (line 9 x line 71)				3,113,467	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				3,113,467	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				3,113,467	83.00
84.00 Program inpatient ancillary services (see instructions)				944,485	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				4,057,952	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 2:09 pm	
			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 2:09 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		72,946,897		30.00
31.00	03100	INTENSIVE CARE UNIT		29,379,520		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.186012	24,181,428	4,498,036	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207271	33,399	6,923	52.00
53.00	05300	ANESTHESIOLOGY	0.023871	7,314,446	174,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162209	10,761,028	1,745,536	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272276	342,082	93,141	55.00
57.00	05700	CT SCAN	0.018440	23,358,728	430,735	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.037510	6,506,701	244,066	58.00
60.00	06000	LABORATORY	0.082670	50,057,166	4,138,226	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.189008	2,872,052	542,841	62.00
65.00	06500	RESPIRATORY THERAPY	0.182133	12,284,447	2,237,403	65.00
66.00	06600	PHYSICAL THERAPY	0.407527	1,503,588	612,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.286779	1,037,619	297,567	67.00
68.00	06800	SPEECH PATHOLOGY	0.225299	507,784	114,403	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045557	28,089,373	1,279,668	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.227478	451,915	102,801	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.135984	30,320,158	4,123,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225924	25,185,409	5,689,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123836	74,282,863	9,198,893	73.00
74.00	07400	RENAL DIALYSIS	0.377509	1,471,742	555,596	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.897040	2,484	2,228	90.00
90.01	09001	OUTPATIENT INFUSION	0.387462	18,954	7,344	90.01
90.02	04950	ONCOLOGY	0.399712	0	0	90.02
91.00	09100	EMERGENCY	0.224523	10,040,750	2,254,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488396	968,244	472,886	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.642122	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		311,592,360	38,823,072	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)		311,592,360		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 2:09 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		5,157,071		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.186012	70,753	13,161	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207271	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.023871	6,809	163	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162209	130,166	21,114	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.272276	52,304	14,241	55.00
57.00	05700 CT SCAN	0.018440	110,087	2,030	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.037510	85,018	3,189	58.00
60.00	06000 LABORATORY	0.082670	979,655	80,988	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.189008	57,042	10,781	62.00
65.00	06500 RESPIRATORY THERAPY	0.182133	272,029	49,545	65.00
66.00	06600 PHYSICAL THERAPY	0.407527	1,262,746	514,603	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286779	1,211,635	347,471	67.00
68.00	06800 SPEECH PATHOLOGY	0.225299	310,344	69,920	68.00
69.00	06900 ELECTROCARDIOLOGY	0.045557	81,118	3,695	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.227478	7,161	1,629	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.135984	116,402	15,829	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.225924	39,609	8,949	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.123836	1,400,553	173,439	73.00
74.00	07400 RENAL DIALYSIS	0.377509	104,401	39,412	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.897040	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.387462	0	0	90.01
90.02	04950 ONCOLOGY	0.399712	0	0	90.02
91.00	09100 EMERGENCY	0.224523	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.488396	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.642122	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,297,832	1,370,159	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)		6,297,832		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 2:09 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.186012	66,173	12,309	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207271	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.023871	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162209	156,271	25,349	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.272276	0	0	55.00
57.00	05700 CT SCAN	0.018440	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.037510	0	0	58.00
60.00	06000 LABORATORY	0.082670	1,114,802	92,161	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.189008	71,540	13,522	62.00
65.00	06500 RESPIRATORY THERAPY	0.182133	455,039	82,878	65.00
66.00	06600 PHYSICAL THERAPY	0.407527	570,512	232,499	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286779	594,099	170,375	67.00
68.00	06800 SPEECH PATHOLOGY	0.225299	38,285	8,626	68.00
69.00	06900 ELECTROCARDIOLOGY	0.045557	47,646	2,171	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.227478	5,124	1,166	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.135984	126,605	17,216	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.225924	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.123836	1,992,963	246,801	73.00
74.00	07400 RENAL DIALYSIS	0.377509	104,401	39,412	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.897040	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.387462	0	0	90.01
90.02	04950 ONCOLOGY	0.399712	0	0	90.02
91.00	09100 EMERGENCY	0.224523	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.488396	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.642122	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,343,460	944,485	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)		5,343,460		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		56,631,659	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)		2,760,067	2.04
3.00	Managed Care Simulated Payments		18,479,029	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		271.28	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		13.16	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		13.16	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		17.07	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		13.16	12.00
13.00	Total allowable FTE count for the prior year.		13.16	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		13.16	14.00
15.00	Sum of lines 12 through 14 divided by 3.		13.16	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		13.16	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.048511	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.051719	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.048511	21.00
22.00	IME payment adjustment (see instructions)		1,480,975	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		483,245	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		3.91	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		1,480,975	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		483,245	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.16	31.00
32.00	Sum of lines 30 and 31		29.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.66	33.00
34.00	Disproportionate share adjustment (see instructions)		1,933,971	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 2:09 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000473771		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	3,927,568	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	3,927,568	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,927,568		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (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 (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)		66,734,240		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		68,923,634		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			69,406,879	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			4,726,968	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).			605,935	52.00
53.00	Nursing and Allied Health Managed Care payment			398,596	53.00
54.00	Special add-on payments for new technologies			1,188,318	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			1,890,145	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			488,254	58.00
59.00	Total (sum of amounts on lines 49 through 58)			78,705,095	59.00
60.00	Primary payer payments			16,762	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			78,688,333	61.00
62.00	Deductibles billed to program beneficiaries			5,636,160	62.00
63.00	Coinsurance billed to program beneficiaries			115,355	63.00
64.00	Allowable bad debts (see instructions)			1,341,522	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			871,989	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,341,522	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			73,808,807	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)			151,159	70.93
70.94	HRR adjustment amount (see instructions)			-491,467	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		73,468,499	71.00
71.01	Sequestration adjustment (see instructions)		0	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		74,136,154	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)		-667,655	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		4,228,384	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		81,271	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		40,708,368	2.00
3.00	OPPS payments		35,801,079	3.00
4.00	Outlier payment (see instructions)		212,811	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		438,016	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		81,271	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		360,353	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)		360,353	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)		360,353	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		279,082	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)		81,271	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)		36,451,906	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		60,024	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,908,787	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)		30,564,366	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		282,505	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)		30,846,871	30.00
31.00	Primary payer payments		1,825	31.00
32.00	Subtotal (line 30 minus line 31)		30,845,046	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)		756,865	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		491,962	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		756,865	36.00
37.00	Subtotal (see instructions)		31,337,008	37.00
38.00	MSP-LCC reconciliation amount from PS&R		595	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)		31,336,413	40.00
40.01	Sequestration adjustment (see instructions)		0	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		31,406,088	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)		-69,675	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Subprovider - IRF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		371	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		25	2.00
3.00	OPPS payments		200	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)		371	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,994	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)		2,994	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)		2,994	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,623	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)		371	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)		200	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		571	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)		571	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		571	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)		571	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		571	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		950	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-379	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		2,948	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,948	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		23,809	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)		23,809	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)		23,809	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		20,861	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)		2,948	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,948	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,948	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,948	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)		2,948	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,948	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		23,809	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-20,861	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 2:09 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		76,511,015		31,475,794	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	02/03/2021	51,774	02/03/2021	63,834	3.50
3.51		09/27/2021	2,323,087	09/27/2021	5,872	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)		-2,374,861		-69,706	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)		74,136,154		31,406,088	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		667,655		69,675	6.02
7.00	Total Medicare program liability (see instructions)		73,468,499		31,336,413	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

 Period:
 From 10/01/2020
 To 09/30/2021

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/28/2022 2:09 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5,174,111		950		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0		3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	02/25/2021	18,968		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)		18,968		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,193,079		950		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		149,228		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		379		6.02
7.00	Total Medicare program liability (see instructions)		5,342,307		571		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0015
 Component CCN: 14-5643

 Period:
 From 10/01/2020
 To 09/30/2021

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/28/2022 2:09 pm

		Title XVIII		Skilled Nursing Facility	PPS
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		1,611,815		23,809
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,611,815		23,809
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		30,704		0
6.02	SETTLEMENT TO PROGRAM		0		20,861
7.00	Total Medicare program liability (see instructions)		1,642,519		2,948
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			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 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part III Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,654,260 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0267 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			126,596 3.00
4.00	Outlier Payments			393,609 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			13.073973 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			5,174,465 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			5,174,465 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			5,174,465 19.00
20.00	Deductibles			26,104 20.00
21.00	Subtotal (line 19 minus line 20)			5,148,361 21.00
22.00	Coinsurance			24,486 22.00
23.00	Subtotal (line 21 minus line 22)			5,123,875 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,123,875 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			218,432 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,342,307 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			5,193,079 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			149,228 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			393,609 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1,725,354 1.00
2.00	Routine service other pass through costs			18,813 2.00
3.00	Ancillary service other pass through costs			11,337 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,755,504 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			113,539 7.00
8.00	Allowable bad debts (see instructions)			853 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			853 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			554 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			1,642,519 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			1,642,519 15.00
15.01	Sequestration adjustment (see instructions)			0 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			1,611,815 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			30,704 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015		Period: From 10/01/2020 To 09/30/2021		Worksheet E-4 Date/Time Prepared: 2/28/2022 2:09 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					17.07	6.00
7.00	Enter the lesser of line 5 or line 6					17.07	7.00
		Primary Care	Other	Total			
		1.00	2.00	3.00			
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.07	0.00	17.07		8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	17.07	0.00	17.07		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01	
11.00	Total weighted FTE count	17.07	0.00	17.07		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.00	0.00	17.00		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	17.30	0.00	17.30		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.12	0.00	17.12		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	17.12	0.00	17.12		17.00	
18.00	Per resident amount	90,958.03	0.00	90,958.03		18.00	
19.00	Approved amount for resident costs	1,557,201	0	1,557,201		19.00	
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00	23.00
24.00	Multiply line 22 time line 23					0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)					1,557,201	25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	32,332	2,089	5,574			26.00
27.00	Total Inpatient Days (see instructions)	69,554	69,554	69,554			27.00
28.00	Ratio of inpatient days to total inpatient days	0.464847	0.030034	0.080139			28.00
29.00	Program direct GME amount	723,860	46,769	124,793	895,422		29.00
29.01	Percent reduction for MA DGME		4.07	4.07			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,903	5,079	6,982		30.00
31.00	Net Program direct GME amount				888,440		31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet E-4 Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Hospital	PPS
			1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		3,981,224	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		88,739,486	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		16,762	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		88,722,724	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		41,367,881	42.00
43.00	Primary payer payments (see instructions)		2,650	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		41,365,231	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		130,087,955	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.682021	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.317979	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		888,440	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		605,935	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		282,505	50.00

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

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/28/2022 2:09 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	112,562,897	0	0	0	1.00
2.00 Temporary investments	223,827,124	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	308,752,820	0	0	0	4.00
5.00 Other receivable	15,813,926	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-231,952,418	0	0	0	6.00
7.00 Inventory	9,881,554	0	0	0	7.00
8.00 Prepaid expenses	10,150,811	0	0	0	8.00
9.00 Other current assets	225,471	0	0	0	9.00
10.00 Due from other funds	5,956,840	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	455,219,025	0	0	0	11.00
FIXED ASSETS					
12.00 Land	16,256,695	0	0	0	12.00
13.00 Land improvements	10,950,050	0	0	0	13.00
14.00 Accumulated depreciation	-5,930,657	0	0	0	14.00
15.00 Buildings	319,814,172	0	0	0	15.00
16.00 Accumulated depreciation	-106,800,872	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	224,754,308	0	0	0	23.00
24.00 Accumulated depreciation	-139,648,527	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)	319,395,169	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	6,646,027	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	620,299	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	7,266,326	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	781,880,520	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	23,871,573	0	0	0	37.00
38.00 Salaries, wages, and fees payable	24,987,171	0	0	0	38.00
39.00 Payroll taxes payable	782,435	0	0	0	39.00
40.00 Notes and loans payable (short term)	2,518,323	0	0	0	40.00
41.00 Deferred income	1,638,490	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	70,968,470	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	124,766,462	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	116,321,788	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	33,082,793	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	149,404,581	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	274,171,043	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	507,709,477	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	507,709,477	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	781,880,520	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/28/2022 2:09 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		422,642,838		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		58,732,998				2.00
3.00	Total (sum of line 1 and line 2)		481,375,836		0		3.00
4.00	PENSION LIABILITY ADJUSTMENT	24,793,360		0		0	4.00
5.00	CHANGE IN RESTRICTED ASSETS	1,939,206		0		0	5.00
6.00	OTHER	84,143		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)		26,816,709		0		10.00
11.00	Subtotal (line 3 plus line 10)		508,192,545		0		11.00
12.00	EQUITY ADJ FROM ACQ OF PHARMACIES	483,068		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)		483,068		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		507,709,477		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	PENSION LIABILITY ADJUSTMENT		0				4.00
5.00	CHANGE IN RESTRICTED ASSETS		0				5.00
6.00	OTHER		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	EQUITY ADJ FROM ACQ OF PHARMACIES		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: 14-0015

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 2:09 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	168,746,629		168,746,629	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,042,016		8,042,016	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	5,836,439		5,836,439	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)	182,625,084		182,625,084	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	69,792,649		69,792,649	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)	69,792,649		69,792,649	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	252,417,733		252,417,733	17.00
18.00	Ancillary services	698,240,017	965,009,444	1,663,249,461	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,617,304	1,617,304	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		7,737,387	7,737,387	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	405,415	5,676,571	6,081,986	26.00
27.00	NURSERY	3,585,837	0	3,585,837	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	954,649,002	980,040,706	1,934,689,708	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		524,912,972		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)		524,912,972		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/28/2022 2:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,934,689,708	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,433,919,086	2.00
3.00	Net patient revenues (line 1 minus line 2)	500,770,622	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	524,912,972	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-24,142,350	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	34,112,728	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,573,706	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	104,608	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	4,624,098	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	2,986,626	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	27,395,223	24.00
24.01	TRANSFERS	1,772,688	24.01
24.02	TRANSFERS	2,020,845	24.02
24.03	RETAIL PHARMACIES	20,713	24.03
24.50	COVID-19 PHE Funding	8,264,113	24.50
25.00	Total other income (sum of lines 6-24)	82,875,348	25.00
26.00	Total (line 5 plus line 25)	58,732,998	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)	58,732,998	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015

Period:

Worksheet H

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures			0		0	0
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	0	0
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	709,608	0	0	0	0	709,608
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	1,124,904	0	132,715	0	330,926	1,588,545
7.00 Physical Therapy	917,116	0	73,908	0	184,290	1,175,314
8.00 Occupational Therapy	194,352	0	20,719	0	51,663	266,734
9.00 Speech Pathology	34,587	0	2,139	0	5,333	42,059
10.00 Medical Social Services	95,610	0	103	0	257	95,970
11.00 Home Health Aide	223,301	0	28,115	0	70,105	321,521
12.00 Supplies (see instructions)	0	0	0	0	0	0
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	3,299,478	0	257,699	0	642,574	4,199,751
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00 Capital Related - Movable Equipment	0	0	0	0		2.00
3.00 Plant Operation & Maintenance	0	0	0	0		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	0	709,608	0	709,608		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	-19,948	1,568,597	-3,434	1,565,163		6.00
7.00 Physical Therapy	0	1,175,314	0	1,175,314		7.00
8.00 Occupational Therapy	0	266,734	0	266,734		8.00
9.00 Speech Pathology	0	42,059	0	42,059		9.00
10.00 Medical Social Services	0	95,970	0	95,970		10.00
11.00 Home Health Aide	0	321,521	0	321,521		11.00
12.00 Supplies (see instructions)	0	0	0	0		12.00
13.00 Drugs	0	0	0	0		13.00
14.00 DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0		15.00
16.00 Respiratory Therapy	0	0	0	0		16.00
17.00 Private Duty Nursing	0	0	0	0		17.00
18.00 Clinic	0	0	0	0		18.00
19.00 Health Promotion Activities	0	0	0	0		19.00
20.00 Day Care Program	0	0	0	0		20.00
21.00 Home Delivered Meals Program	0	0	0	0		21.00
22.00 Homemaker Service	0	0	0	0		22.00
23.00 All Others (specify)	0	0	0	0		23.00
23.50 Telemedicine	0	0	0	0		23.50
24.00 Total (sum of lines 1-23)	-19,948	4,179,803	-3,434	4,176,369		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0015

Period:

Worksheet H-1

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 2:09 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)						
			Bldgs & Fixtures	Movable Equipment									
		0	1.00	2.00	3.00	4.00	4A.00						
GENERAL SERVICE COST CENTERS													
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00					
2.00	Capital Related - Movable Equipment	0		0			0	2.00					
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00					
4.00	Transportation	0	0	0	0	0	0	4.00					
5.00	Administrative and General	709,608	0	0	0	0	709,608	5.00					
HHA REIMBURSABLE SERVICES													
6.00	Skilled Nursing Care	1,565,163	0	0	0	0	1,565,163	6.00					
7.00	Physical Therapy	1,175,314	0	0	0	0	1,175,314	7.00					
8.00	Occupational Therapy	266,734	0	0	0	0	266,734	8.00					
9.00	Speech Pathology	42,059	0	0	0	0	42,059	9.00					
10.00	Medical Social Services	95,970	0	0	0	0	95,970	10.00					
11.00	Home Health Aide	321,521	0	0	0	0	321,521	11.00					
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00					
13.00	Drugs	0	0	0	0	0	0	13.00					
14.00	DME	0	0	0	0	0	0	14.00					
HHA NONREIMBURSABLE SERVICES													
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00					
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00					
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00					
18.00	Clinic	0	0	0	0	0	0	18.00					
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00					
20.00	Day Care Program	0	0	0	0	0	0	20.00					
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00					
22.00	Homemaker Service	0	0	0	0	0	0	22.00					
23.00	All Others (specify)	0	0	0	0	0	0	23.00					
23.50	Telemedicine	0	0	0	0	0	0	23.50					
24.00	Total (sum of lines 1-23)	4,176,369	0	0	0	0	4,176,369	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	709,608								5.00			
HHA REIMBURSABLE SERVICES													
6.00	Skilled Nursing Care	320,371	1,885,534						6.00				
7.00	Physical Therapy	240,574	1,415,888						7.00				
8.00	Occupational Therapy	54,598	321,332						8.00				
9.00	Speech Pathology	8,609	50,668						9.00				
10.00	Medical Social Services	19,644	115,614						10.00				
11.00	Home Health Aide	65,812	387,333						11.00				
12.00	Supplies (see instructions)	0	0						12.00				
13.00	Drugs	0	0						13.00				
14.00	DME	0	0						14.00				
HHA NONREIMBURSABLE SERVICES													
15.00	Home Dialysis Aide Services	0	0						15.00				
16.00	Respiratory Therapy	0	0						16.00				
17.00	Private Duty Nursing	0	0						17.00				
18.00	Clinic	0	0						18.00				
19.00	Health Promotion Activities	0	0						19.00				
20.00	Day Care Program	0	0						20.00				
21.00	Home Delivered Meals Program	0	0						21.00				
22.00	Homemaker Service	0	0						22.00				
23.00	All Others (specify)	0	0						23.00				
23.50	Telemedicine	0	0						23.50				
24.00	Total (sum of lines 1-23)		4,176,369						24.00				

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet H-1

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 2:09 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	- 709,608	5.00
						3,466,761	
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	1,565,163	6.00
7.00	Physical Therapy	0	0	0	0	1,175,314	7.00
8.00	Occupational Therapy	0	0	0	0	266,734	8.00
9.00	Speech Pathology	0	0	0	0	42,059	9.00
10.00	Medical Social Services	0	0	0	0	95,970	10.00
11.00	Home Health Aide	0	0	0	0	321,521	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	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)	0	0	0	0	- 709,608	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	709,608	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.204689	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2020

Part I

To 09/30/2021

Date/Time Prepared:

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	MOB PHASE I	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	1,885,534	0	0	0	0	0	2.00
3.00	Physical Therapy	1,415,888	0	0	0	0	0	3.00
4.00	Occupational Therapy	321,332	0	0	0	0	0	4.00
5.00	Speech Pathology	50,668	0	0	0	0	0	5.00
6.00	Medical Social Services	115,614	0	0	0	0	0	6.00
7.00	Home Health Aide	387,333	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,176,369	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	MVBLE EQUIP			
		1.05	1.06	1.07	2.00	4.00	4A	
1.00	Administrative and General	27,782	0	0	642	251,108	279,532	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	1,885,534	2.00
3.00	Physical Therapy	0	0	0	0	0	1,415,888	3.00
4.00	Occupational Therapy	0	0	0	0	0	321,332	4.00
5.00	Speech Pathology	0	0	0	0	0	50,668	5.00
6.00	Medical Social Services	0	0	0	0	0	115,614	6.00
7.00	Home Health Aide	0	0	0	0	0	387,333	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)	27,782	0	0	642	251,108	4,455,901	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 2:09 pmHome Health
Agency I

PPS

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	86,596	53,896	0	31,029	0	0	1.00
2.00	Skilled Nursing Care	584,121	0	0	0	0	0	2.00
3.00	Physical Therapy	438,628	0	0	0	0	0	3.00
4.00	Occupational Therapy	99,545	0	0	0	0	0	4.00
5.00	Speech Pathology	15,696	0	0	0	0	0	5.00
6.00	Medical Social Services	35,816	0	0	0	0	0	6.00
7.00	Home Health Aide	119,992	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,380,394	53,896	0	31,029	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	
		13.00	16.00	20.00	21.00	22.00	23.00	
1.00	Administrative and General	799,805	0	37,348	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	799,805	0	37,348	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 2:09 pmHome Health
Agency I

PPS

Cost Center Description		PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	
		23.01	23.02	23.03	23.04	23.05	24.00	
1.00	Administrative and General	0	0	0	0	0	1,288,206	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2,469,655	2.00
3.00	Physical Therapy	0	0	0	0	0	1,854,516	3.00
4.00	Occupational Therapy	0	0	0	0	0	420,877	4.00
5.00	Speech Pathology	0	0	0	0	0	66,364	5.00
6.00	Medical Social Services	0	0	0	0	0	151,430	6.00
7.00	Home Health Aide	0	0	0	0	0	507,325	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	6,758,373	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		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	1,288,206					1.00
2.00	Skilled Nursing Care	0	2,469,655	581,594	3,051,249			2.00
3.00	Physical Therapy	0	1,854,516	436,733	2,291,249			3.00
4.00	Occupational Therapy	0	420,877	99,115	519,992			4.00
5.00	Speech Pathology	0	66,364	15,629	81,993			5.00
6.00	Medical Social Services	0	151,430	35,661	187,091			6.00
7.00	Home Health Aide	0	507,325	119,474	626,799			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	6,758,373	1,288,206	6,758,373			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.			0.235497				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015
HHA CCN: 14-7031Period:
From 10/01/2020
To 09/30/2021Worksheet H-2
Part II
Date/Time Prepared:
2/28/2022 2:09 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		Agency 1				
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	OAK STREET MALL (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	0	2,050	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	2,050	20.00
21.00	Total cost to be allocated	0	0	0	0	0	27,782	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	13.552195	22.00
Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation		
		BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.06	1.07	2.00			5.00	
1.00	Administrative and General	0	0	641	3,285,895	0	279,532	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	1,885,534	2.00
3.00	Physical Therapy	0	0	0	0	0	1,415,888	3.00
4.00	Occupational Therapy	0	0	0	0	0	321,332	4.00
5.00	Speech Pathology	0	0	0	0	0	50,668	5.00
6.00	Medical Social Services	0	0	0	0	0	115,614	6.00
7.00	Home Health Aide	0	0	0	0	0	387,333	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	641	3,285,895		4,455,901	20.00
21.00	Total cost to be allocated	0	0	642	251,108		1,380,394	21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.001560	0.076420		0.309790	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
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Cost Center Description		Agency 1		Agency 2		Agency 3		Agency 4	
		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)		
		6.00	8.00	9.00	10.00	11.00	13.00		
1.00	Administrative and General	2,050	0	505	0	0	90,705	1.00	
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	2,050	0	505	0	0	90,705	20.00	
21.00	Total cost to be allocated	53,896	0	31,029	0	0	799,805	21.00	
22.00	Unit cost multiplier	26.290732	0.000000	61.443564	0.000000	0.000000	8.817651	22.00	
Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)		
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
				16.00	20.00				21.00
1.00	Administrative and General	0	204	0	0	0	0	1.00	
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	0	204	0	0	0	0	20.00	
21.00	Total cost to be allocated	0	37,348	0	0	0	0	21.00	
22.00	Unit cost multiplier	0.000000	183.078431	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part II
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Cost Center Description		PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATORY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)			
		23.02	23.03	23.04	23.05			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet H-3

HHA CCN: 14-7031

From 10/01/2020

Part I

To 09/30/2021

Date/Time Prepared:
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Title XVIII

Home Health
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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	3,051,249		3,051,249	21,900	139.33	1.00
2.00	Physical Therapy	3.00	2,291,249	0	2,291,249	12,195	187.88	2.00
3.00	Occupational Therapy	4.00	519,992	0	519,992	3,418	152.13	3.00
4.00	Speech Pathology	5.00	81,993	0	81,993	351	233.60	4.00
5.00	Medical Social Services	6.00	187,091		187,091	19	9,846.89	5.00
6.00	Home Health Aide	7.00	626,799		626,799	4,637	135.17	6.00
7.00	Total (sum of lines 1-6)		6,758,373	0	6,758,373	42,520		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	8,285			8.00
8.01	Skilled Nursing Care		99926	0	1,551			8.01
9.00	Physical Therapy		99914	0	5,195			9.00
9.01	Physical Therapy		99926	0	1,056			9.01
10.00	Occupational Therapy		99914	0	1,559			10.00
10.01	Occupational Therapy		99926	0	214			10.01
11.00	Speech Pathology		99914	0	129			11.00
11.01	Speech Pathology		99926	0	28			11.01
12.00	Medical Social Services		99914	0	11			12.00
12.01	Medical Social Services		99926	0	2			12.01
13.00	Home Health Aide		99914	0	2,520			13.00
13.01	Home Health Aide		99926	0	310			13.01
14.00	Total (sum of lines 8-13)			0	20,860			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	101,982	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		
				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	9,836		0	1,370,450		1.00
2.00	Physical Therapy	0	6,251		0	1,174,438		2.00
3.00	Occupational Therapy	0	1,773		0	269,726		3.00
4.00	Speech Pathology	0	157		0	36,675		4.00
5.00	Medical Social Services	0	13		0	128,010		5.00
6.00	Home Health Aide	0	2,830		0	382,531		6.00
7.00	Total (sum of lines 1-6)	0	20,860		0	3,361,830		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet H-3

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
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Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
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	101,982	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	1,370,450							1.00
2.00	Physical Therapy	1,174,438							2.00
3.00	Occupational Therapy	269,726							3.00
4.00	Speech Pathology	36,675							4.00
5.00	Medical Social Services	128,010							5.00
6.00	Home Health Aide	382,531							6.00
7.00	Total (sum of lines 1-6)	3,361,830							7.00
Cost Center Description									
		12.00							
	Limitation Cost Computation								
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet H-3

HHA CCN: 14-7031

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
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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	0.407527	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.286779	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.225299	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.135984	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.123836	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2020 To 09/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	3,429,872	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	3,429,872	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	3,429,872	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	825	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	-825
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	3,473,668
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	79,101
13.00	Total PPS Reimbursement - LUPA Episodes		0	47,320
14.00	Total PPS Reimbursement - PEP Episodes		0	14,180
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	22,963
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	3,636,407
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	3,636,407
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	3,636,407
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,636,407
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	3,636,407
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	3,636,407
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: 14-0015

Period:

Worksheet H-5

HHA CCN: 14-7031

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 2:09 pm

Home Health
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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		3,636,407	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		3,636,407	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		3,636,407	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0

Hospice CCN: 14-1501

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

						Hospice I		2/28/2022 2:00 pm	
		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	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	0	2.00	
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	0	3.00	
4.00	ADMINISTRATIVE & GENERAL*	477,741	59,462	537,203	0	537,203	0	4.00	
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	0	5.00	
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	0	6.00	
7.00	HOUSEKEEPING*	0	0	0	0	0	0	7.00	
8.00	DIETARY*	0	0	0	0	0	0	8.00	
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	0	9.00	
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	0	10.00	
11.00	MEDICAL RECORDS*	0	0	0	0	0	0	11.00	
12.00	STAFF TRANSPORTATION*	0	124,011	124,011	0	124,011	0	12.00	
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	17,902	17,902	0	13.00	
14.00	PHARMACY*	0	0	0	0	0	0	14.00	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	0	15.00	
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	0	16.00	
17.00	PATIENT/RESIDENTIAL CARE SERVICES							17.00	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	0	25.00	
26.00	PHYSICIAN SERVICES**	85,569	75,348	160,917	0	160,917	0	26.00	
27.00	NURSE PRACTITIONER**	125,473	3,892	129,365	0	129,365	0	27.00	
28.00	REGISTERED NURSE**	712,532	0	712,532	-305	712,227	0	28.00	
29.00	LPN/LVN**	0	0	0	0	0	0	29.00	
30.00	PHYSICAL THERAPY**	0	0	0	0	0	0	30.00	
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	0	31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	0	32.00	
33.00	MEDICAL SOCIAL SERVICES**	111,715	0	111,715	0	111,715	0	33.00	
34.00	SPIRITUAL COUNSELING**	76,288	0	76,288	0	76,288	0	34.00	
35.00	DIETARY COUNSELING**	0	0	0	0	0	0	35.00	
36.00	COUNSELING - OTHER**	0	0	0	0	0	0	36.00	
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	92,880	0	92,880	0	92,880	0	37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	177,945	177,945	0	177,945	0	38.00	
39.00	PATIENT TRANSPORTATION**	0	4,603	4,603	0	4,603	0	39.00	
40.00	IMAGING SERVICES**	0	0	0	0	0	0	40.00	
41.00	LABS & DIAGNOSTICS**	0	180	180	0	180	0	41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	75,224	75,224	-7,235	67,989	0	42.00	
42.50	DRUGS CHARGED TO PATIENTS**	0	224,341	224,341	0	224,341	0	42.50	
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	0	43.00	
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	0	44.00	
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	0	45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	1,692	0	1,692	0	1,692	0	46.00	
NONREIMBURSABLE COST CENTERS									
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	0	60.00	
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	0	61.00	
62.00	FUNDRAISING*	0	0	0	0	0	0	62.00	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	0	63.00	
64.00	PALLIATIVE CARE PROGRAM*	236,890	0	236,890	0	236,890	0	64.00	
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	0	65.00	
66.00	RESIDENTIAL CARE*	0	0	0	0	0	0	66.00	
67.00	ADVERTISING*	0	0	0	0	0	0	67.00	
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	0	68.00	
69.00	THRIFT STORE*	0	0	0	0	0	0	69.00	
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	0	70.00	
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	0	71.00	
100.00	TOTAL	1,920,780	745,006	2,665,786	10,362	2,676,148	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: 14-0015

Period:

Worksheet 0

Hospice CCN: 14-1501

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I	
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	537,203		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	124,011		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	17,902		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	144,956	144,956		25.00
26.00	PHYSICIAN SERVICES**	-18,398	142,519		26.00
27.00	NURSE PRACTITIONER**	0	129,365		27.00
28.00	REGISTERED NURSE**	0	712,227		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	111,715		33.00
34.00	SPIRITUAL COUNSELING**	0	76,288		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	92,880		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	177,945		38.00
39.00	PATIENT TRANSPORTATION**	0	4,603		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	180		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	67,989		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	224,341		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	1,692		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	236,890		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	126,558	2,802,706		100.00

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

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE			Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet 0-2
			Hospice CCN: 14-1501		Date/Time Prepared: 2/28/2022 2:09 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	85,569	75,348	160,917	0	160,917	26.00
27.00	NURSE PRACTITIONER	125,473	3,892	129,365	0	129,365	27.00
28.00	REGISTERED NURSE	678,390	0	678,390	-305	678,085	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	108,712	0	108,712	0	108,712	33.00
34.00	SPIRITUAL COUNSELING	74,415	0	74,415	0	74,415	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	92,880	0	92,880	0	92,880	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	177,945	177,945	0	177,945	38.00
39.00	PATIENT TRANSPORTATION	0	4,603	4,603	0	4,603	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	180	180	0	180	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	75,224	75,224	-7,235	67,989	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	224,341	224,341	0	224,341	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)	1,692	0	1,692	0	1,692	46.00
100.00	TOTAL *	1,167,131	561,533	1,728,664	-7,540	1,721,124	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	-18,398	142,519	26.00
27.00	NURSE PRACTITIONER	0	129,365	27.00
28.00	REGISTERED NURSE	0	678,085	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	108,712	33.00
34.00	SPIRITUAL COUNSELING	0	74,415	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	92,880	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	177,945	38.00
39.00	PATIENT TRANSPORTATION	0	4,603	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	180	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	67,989	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	224,341	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	1,692	46.00
100.00	TOTAL *	-18,398	1,702,726	100.00

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

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

Provider CCN: 14-0015

Period:
From 10/01/2020
To 09/30/2021

Worksheet 0-4

Hospice CCN: 14-1501

Date/Time Prepared:
2/28/2022 2:09 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	34,142	0	34,142	0	34,142	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	3,003	0	3,003	0	3,003	33.00
34.00	SPIRITUAL COUNSELING	1,873	0	1,873	0	1,873	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	39,018	0	39,018	0	39,018	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	144,956	144,956	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	34,142	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	3,003	33.00
34.00	SPIRITUAL COUNSELING	0	1,873	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	144,956	183,974	100.00

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

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

Provider CCN: 14-0015

Period:

Worksheet 0-5

Hospice CCN: 14-1501

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 2:09 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,103	7,103	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	147,936	147,936	3.00
4.00	ADMINISTRATIVE & GENERAL	537,203	916,280	1,453,483	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	469,848	469,848	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	124,011	0	124,011	12.00
13.00	VOLUNTEER SERVICE COORDINATION	17,902	0	17,902	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	3,479	3,479	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,702,726	0	1,702,726	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	183,974	0	183,974	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	236,890	0	236,890	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	2,802,706	1,544,646	4,347,352	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 2:09 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0		1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,103			7,103			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	147,936		0	0	147,936		3.00
4.00	ADMINISTRATIVE & GENERAL	1,453,483		0	7,103	36,509	1,497,095	4.00
5.00	PLANT OPERATION & MAINTENANCE	0		0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0		0	0	0	0	6.00
7.00	HOUSEKEEPING	0		0	0	0	0	7.00
8.00	DIETARY	0		0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	469,848		0	0	0	469,848	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	124,011		0	0	0	124,011	12.00
13.00	VOLUNTEER SERVICE COORDINATION	17,902		0	0	1,173	19,075	13.00
14.00	PHARMACY	0		0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	3,479		0	0	0	3,479	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0	0	0	0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,702,726				89,169	1,791,895	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	183,974		0	0	2,982	186,956	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	236,890		0	0	18,103	254,993	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0		0	0	0	0	66.00
67.00	ADVERTISING	0		0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	0	0	0	68.00
69.00	THRIFT STORE	0		0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0	0	0	0	99.00
100.00	TOTAL	4,347,352		0	7,103	147,936	4,347,352	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2020
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Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	1,497,095						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	246,787	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			0		10.00
11.00	MEDICAL RECORDS	0	0			0		11.00
12.00	STAFF TRANSPORTATION	65,137	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	10,019	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	1,827	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	941,192						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	98,198	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	133,935	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	1,497,095	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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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	716,635					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			189,148		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	29,094	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	716,635	0	0	186,878	28,745	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	2,270	349	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	716,635	0	0	189,148	29,094	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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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		5,306			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	5,306		3,670,651	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	287,773	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		388,928	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		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	5,306	0	4,347,352	100.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2020
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Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		7,095				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,935,822			3.00
4.00	ADMINISTRATIVE & GENERAL	0	7,095	477,741	-1,497,095	2,850,257	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	469,848	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	124,011	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	15,347	0	19,075	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	3,479	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1,166,826	0	1,791,895	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	39,018	0	186,956	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	236,890	0	254,993	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	7,103	147,936		1,497,095	100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.001128	0.076420		0.525249	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2020
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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		53,285	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	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					53,285	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0	716,635	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	13.449094	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2020
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Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0				10.00
11.00	MEDICAL RECORDS		0			11.00
12.00	STAFF TRANSPORTATION			42,500		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	42,500	13.00
14.00	PHARMACY			0	0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	41,990	41,990	0 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	510	510	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)	0	0	189,148	29,094	0 100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	4.450541	0.684565	0.000000 101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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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		19			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	19			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	5,306	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	279.263158	0.000000		101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-7

Hospice CCN: 14-1501

From 10/01/2020
To 09/30/2021

Date/Time Prepared:
2/28/2022 2:09 pm

Hospice I

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.407527	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.286779	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.225299	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.123836	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.082670	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.135984	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	93.99	0.642122	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.272276	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0015

Period:

Worksheet 0-8

Hospice CCN: 14-1501

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			3,670,651	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			20,267	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			181.11	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	18,488	971		9.00
10.00	Program cost (line 8 times line 9)	3,348,362	175,858		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			287,773	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			510	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			564.26	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	471	21		19.00
20.00	Program cost (line 18 times line 19)	265,766	11,849		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,958,424	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			20,777	22.00
23.00	Average cost per diem (line 21 divided by line 22)			190.52	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0015	Period: From 10/01/2020 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 2/28/2022 2:09 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,262,628	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		376,104	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)		180.81	3.00
4.00	Number of interns & residents (see instructions)		13.16	4.00
5.00	Indirect medical education percentage (see instructions)		2.07	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)		88,236	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		4,726,968	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015

Period:

Worksheet M-1

Component CCN: 14-3422

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	190,401	0	190,401	0	190,401
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	190,000	0	190,000	-6,985	183,015
10.00	Subtotal (sum of lines 1 through 9)	380,401	0	380,401	-6,985	373,416
11.00	Physician Services Under Agreement	0	125,969	125,969	0	125,969
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	63	63	0	63
14.00	Subtotal (sum of lines 11 through 13)	0	126,032	126,032	0	126,032
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	35,180	35,180	0	35,180
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	35,180	35,180	0	35,180
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	380,401	161,212	541,613	-6,985	534,628
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	12,015	4,393	16,408	0	16,408
25.02	Chronic Care Management	39,350	10,463	49,813	0	49,813
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)	51,365	14,856	66,221	0	66,221
FACILITY OVERHEAD						
29.00	Facility Costs	0	92,323	92,323	8,422	100,745
30.00	Administrative Costs	94,953	30,962	125,915	0	125,915
31.00	Total Facility Overhead (sum of lines 29 and 30)	94,953	123,285	218,238	8,422	226,660
32.00	Total facility costs (sum of lines 22, 28 and 31)	526,719	299,353	826,072	1,437	827,509

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015

Period:

Worksheet M-1

Component CCN: 14-3422

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	190,401	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	183,015	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	373,416	10.00	
11.00	Physician Services Under Agreement	0	125,969	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	63	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	126,032	14.00	
15.00	Medical Supplies	0	0	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	35,180	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	35,180	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	534,628	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	16,408	25.01	
25.02	Chronic Care Management	0	49,813	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	66,221	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	-49,049	51,696	29.00	
30.00	Administrative Costs	31,098	157,013	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17,951	208,709	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,951	809,558	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015

Period:

Worksheet M-2

Component CCN: 14-3422

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.31	963	4,200	1,302		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.60	4,325	2,100	3,360		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.91	5,288		4,662	5,288	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)	1.91	5,288			5,288	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)					534,628	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					66,221	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					600,849	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.889788	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					208,709	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					303,039	15.00
16.00	Total overhead (sum of lines 14 and 15)					511,748	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					511,748	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					455,347	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					989,975	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/28/2022 2:09 pm	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			989,975	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			45,381	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			944,594	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,288	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)			5,288	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			178.63	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	347	335	754	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	29,950	29,319	75,400	11.00
12.00	Program covered visits for mental health services (from contractor records)	10	4	10	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	863	350	1,000	13.00
14.00	Limit adjustment for mental health services (see instructions)	863	350	1,000	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	136,882		16.00
16.01	Total program charges (see instructions)(from contractor's records)		376,807		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		61,418		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,311		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.)		67,477		16.04
16.05	Total program cost (see instructions)	0	89,788		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,225		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		57,033		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		89,788		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,476		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		107,264		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)		107,264		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		85,625		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)		21,639		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 VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet M-4

Component CCN: 14-3422

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 2:09 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	373,416	373,416	373,416	373,416	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000817	0.004143	0.000532	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	305	1,547	199	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,671	8,786	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	13,976	10,333	199	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	534,628	534,628	534,628	534,628	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	455,347	455,347	455,347	455,347	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026142	0.019327	0.000372	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,904	8,800	169	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	25,880	19,133	368	0	10.00
11.00	Total number of injections/infusions (from your records)	86	436	28	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	300.93	43.88	13.14	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	36	143	12	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			16	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	10,833	6,275	368	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		45,381			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		17,476			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 2:09 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		85,625	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)		85,625	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		21,639	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		107,264	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00