

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 5/23/2022 11:01 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date:	Time:
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION 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 ST. MARGARETS HEALTH - SPRING VALLEY (14-0143) 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			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			2
3	Signatory Title			3
4	Date			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	-1,742,313	-10,811	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		28		0	10.00
200.00	Total	0	-1,742,313	-10,783	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 600 EAST FIRST ST			PO Box:				1.00		
2.00	City: SPRING VALLEY			State: IL		Zip Code: 61362		County: BUREAU 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ST. MARGARETS HEALTH - SPRING VALLEY	140143	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ST. MARGARETS HEALTH - SPRING VALLEY	14U143	99914		06/23/2003	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		ST. MARGARETS HEALTH - SPRING VALLEY	141595	99914		07/07/1998			
15.00	Hospital-Based Health Clinic - RHC		ST. MARGARETS HEALTH - SPRING VALLEY	148623	99914		01/07/2021	N	N	O
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		
21.00	Type of Control (see instructions)						1			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
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		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	771	87	0	0	0	33	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					10/01/2020	09/30/2021	38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
5/23/2022 11:01 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
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.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	584,952	0			118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y			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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		35H002		140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SISTERS MARY OF THE PRESENTATION HC	Contractor's Name: NORIDIAN ADMIN SVC		Contractor's Number: 03001		141.00	
142.00	Street: 1202 PAGE DR SW PO BOX 10007	PO Box:				142.00	
143.00	City: FARGO	State: ND		Zip Code: 58106-0007		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
		Title XIX		4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 11:01 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part II Date/Time Prepared: 5/23/2022 11:01 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing 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.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/24/2022	Y	03/24/2022		17.00
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			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part II Date/Time Prepared: 5/23/2022 11:01 am	
		Description		Y/N	Y/N		
		0		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions						22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions						24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.						25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.						26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						27.00
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions						29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.						30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.						31.00
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.						33.00
Provider-Based Physicians							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.						34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.						35.00
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?						36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.						37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.						38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.						39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.						40.00
				1.00	2.00		
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DON		TROGLIO		41.00	
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARETS HOSPITAL				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328		DTROGLIO@ABOUTSMG.ORG		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 5/23/2022 11:01 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF ACCOUNTING		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

Health Financial Systems		ST. MARGARETS HEALTH - SPRING VALLEY		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part IX Date/Time Prepared: 5/23/2022 11:01 am	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		44	16,060	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		44				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,495	566	4,478			1.00
2.00	HMO and other (see instructions)	745	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,495	566	4,501			7.00
8.00	INTENSIVE CARE UNIT	329	102	776			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		190	443			13.00
14.00	Total (see instructions)	2,824	858	5,720	0.00	560.17	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	6.80	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	288	199	1,156	0.00	2.01	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	568.98	27.00
28.00	Observation Bed Days		0	1,257			28.00
29.00	Ambulance Trips	296					29.00
30.00	Employee discount days (see instruction)			22			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	33	100			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	653	180	1,428	1.00
2.00 HMO and other (see instructions)			167	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	653	180	1,428	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/23/2022 11:01 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	37,945,356	763,808	38,709,164	1,183,511.20	32.71 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		9,967,585	0	9,967,585	89,731.22	111.08 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		77,949	0	77,949	3,175.00	24.55 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		1,530,612	121,251	1,651,863	60,688.35	27.22 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,791,636	0	1,791,636	17,330.96	103.38 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		453,569	0	453,569	5,308.00	85.45 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		1,042,276	0	1,042,276	6,444.00	161.74 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,049,348	0	7,049,348		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		409,701	0	409,701		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,163,827	0	1,163,827		
24.00	Wage-related costs (RHC/FQHC)		20,582	0	20,582		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		211,709	0	211,709		
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: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/23/2022 11:01 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	225,145	0	225,145	8,316.75	27.07	26.00
27.00	Administrative & General	5.00	3,256,357	-121,251	3,135,106	130,189.30	24.08	27.00
28.00	Administrative & General under contract (see inst.)		1,409,515	0	1,409,515	3,564.35	395.45	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	527,742	0	527,742	22,361.28	23.60	30.00
31.00	Laundry & Linen Service	8.00	0	53,466	53,466	3,743.00	14.28	31.00
32.00	Housekeeping	9.00	630,975	-53,466	577,509	37,573.40	15.37	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	839,169	-621,824	217,345	12,740.90	17.06	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	621,824	621,824	36,449.00	17.06	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,142,216	0	1,142,216	28,617.96	39.91	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,418,845	0	1,418,845	68,480.95	20.72	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
5/23/2022 11:01 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	29,309,337	763,808	30,073,145	1,094,169.33	27.48	1.00
2.00	Excluded area salaries (see instructions)	1,530,612	121,251	1,651,863	60,688.35	27.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)	27,778,725	642,557	28,421,282	1,033,480.98	27.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,287,481	0	3,287,481	29,082.96	113.04	4.00
5.00	Subtotal wage-related costs (see inst.)	7,261,057	0	7,261,057	0.00	25.55	5.00
6.00	Total (sum of lines 3 thru 5)	38,327,263	642,557	38,969,820	1,062,563.94	36.68	6.00
7.00	Total overhead cost (see instructions)	9,449,964	-121,251	9,328,713	352,036.89	26.50	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2022 11:01 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		890,641	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		4,542,595	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		199,152	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		38,463	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		3,121	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		196,378	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		265,757	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,975,821	17.00
18.00	Medicare Taxes - Employers Portion Only		525,389	18.00
19.00	Unemployment Insurance		3,171	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		2,970	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		8,643,458	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0143

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 5/23/2022 11:01 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,791,636	8,643,458	1.00
2.00	Hospital	1,791,636	8,643,458	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0143 Component CCN: 14-8623		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/23/2022 11:01 am	
				RHC I					
				1.00					
Clinic Address and Identification									
1.00	Street			309 SOUTH MCCOY STREET				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			GRANVILLE IL 61326				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			09:00		17:00		09:00	
				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			PUTNAM				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		09:00		17:00	
				11.00					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN:14-0143 Component CCN:14-8623		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/23/2022 11:01 am	
						RHC I			
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			09:00	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0143

Period:

Worksheet S-9

Hospice CCN: 14-1595

From 10/01/2020

PARTS I THROUGH IV

To 09/30/2021

Date/Time Prepared:

5/23/2022 11:01 am

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,275	652	2,001	5,928	11.00
12.00	Hospice Inpatient Respite Care	9	0	0	9	12.00
13.00	Hospice General Inpatient Care	101	2	221	324	13.00
14.00	Total Hospice Days	3,385	654	2,222	6,261	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 5/23/2022 11:01 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.327656	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,444,244	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		31,875,944	6.00
7.00	Medicaid cost (line 1 times line 6)		10,444,344	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		6,000,100	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		3,250	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		6,000,100	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)	1,033,350	901	1,034,251
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	338,583	901	339,484
22.00	Payments received from patients for amounts previously written off as charity care	0	2,032	2,032
23.00	Cost of charity care (line 21 minus line 22)	338,583	0	338,583
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,154,902	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		137,532	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		211,587	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,943,315	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		710,794	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,049,377	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,049,477	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:

5/23/2022 11:01 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,698,078	3,698,078	-446,158	3,251,920	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,523,414	2,523,414	214,958	2,738,372	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	225,145	8,794,121	9,019,266	0	9,019,266	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,256,357	16,429,953	19,686,310	-137,323	19,548,987	5.00
7.00	00700	OPERATION OF PLANT	527,742	1,362,669	1,890,411	0	1,890,411	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,368	178,368	53,466	231,834	8.00
9.00	00900	HOUSEKEEPING	630,975	251,420	882,395	-53,466	828,929	9.00
10.00	01000	DIETARY	839,169	412,256	1,251,425	-927,309	324,116	10.00
11.00	01100	CAFETERIA	0	0	0	927,309	927,309	11.00
13.00	01300	NURSING ADMINISTRATION	1,142,216	106,574	1,248,790	0	1,248,790	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,418,845	388,925	1,807,770	0	1,807,770	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,966,304	1,991,838	4,958,142	-74,750	4,883,392	30.00
31.00	03100	INTENSIVE CARE UNIT	719,495	147,201	866,696	0	866,696	31.00
43.00	04300	NURSERY	53,795	133,183	186,978	0	186,978	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,073,752	3,765,802	5,839,554	0	5,839,554	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	236,329	69,650	305,979	74,750	380,729	52.00
53.00	05300	ANESTHESIOLOGY	0	2,018,187	2,018,187	0	2,018,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	822,614	1,310,388	2,133,002	0	2,133,002	54.00
54.01	05402	MRI	155,124	185,012	340,136	0	340,136	54.01
57.00	05700	CT SCAN	140,493	449,955	590,448	0	590,448	57.00
60.00	06000	LABORATORY	1,136,110	3,238,321	4,374,431	0	4,374,431	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	191,448	191,448	0	191,448	63.00
65.00	06500	RESPIRATORY THERAPY	374,724	376,171	750,895	0	750,895	65.00
66.00	06600	PHYSICAL THERAPY	1,431,884	94,223	1,526,107	0	1,526,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,744	5,131	173,875	0	173,875	67.00
68.00	06800	SPEECH PATHOLOGY	50,728	8,417	59,145	0	59,145	68.00
69.00	06900	ELECTROCARDIOLOGY	93,336	193,550	286,886	0	286,886	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,621	3,153	44,774	0	44,774	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,270	233,024	279,294	0	279,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,249,720	2,249,720	0	2,249,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	758,415	1,857,474	2,615,889	0	2,615,889	73.00
76.00	03020	SONOGRAPHY	182,505	471,388	653,893	0	653,893	76.00
76.01	03040	AUDIOLOGY	0	0	0	270,210	270,210	76.01
76.02	03160	CARDIAC REHAB	78,222	9,469	87,691	0	87,691	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	188,184	188,184	88.00
90.00	09000	CLINIC	15,853,954	3,729,479	19,583,433	779,653	20,363,086	90.00
91.00	09100	EMERGENCY	989,876	1,422,465	2,412,341	0	2,412,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	976,504	976,504	0	976,504	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	1,019,969	1,019,969	-1,019,969	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	496,302	427,262	923,564	0	923,564	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,911,046	60,724,162	97,635,208	-150,445	97,484,763	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	34,377	2,395	36,772	0	36,772	194.00
194.01	07951	OTHER	0	0	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	36,550	14,634	51,184	0	51,184	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	2,235	2,235	0	2,235	194.05
194.06	07956	CHHW	65,456	294,964	360,420	0	360,420	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	224,626	420,076	644,702	0	644,702	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	150,445	150,445	194.20
194.21	07971	OCCUPATIONAL HEALTH	528,899	61,299	590,198	0	590,198	194.21
194.24	07974	SURGICAL ASSOCIATES	0	234	234	0	234	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	144,402	143,974	288,376	0	288,376	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	37,945,356	61,663,973	99,609,329	0	99,609,329	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-17,914	3,234,006	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	0	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,130	2,740,502	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,434,308	7,584,958	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,864,966	14,684,021	5.00
7.00	00700	OPERATION OF PLANT	-1,854	1,888,557	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	231,834	8.00
9.00	00900	HOUSEKEEPING	0	828,929	9.00
10.00	01000	DIETARY	0	324,116	10.00
11.00	01100	CAFETERIA	-191,677	735,632	11.00
13.00	01300	NURSING ADMINISTRATION	-67,521	1,181,269	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,330	1,806,440	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,494,740	3,388,652	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,800	858,896	31.00
43.00	04300	NURSERY	-108,950	78,028	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,839,554	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	380,729	52.00
53.00	05300	ANESTHESIOLOGY	-1,851,000	167,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,133,002	54.00
54.01	05402	MRI	0	340,136	54.01
57.00	05700	CT SCAN	0	590,448	57.00
60.00	06000	LABORATORY	0	4,374,431	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	191,448	63.00
65.00	06500	RESPIRATORY THERAPY	0	750,895	65.00
66.00	06600	PHYSICAL THERAPY	-2,088	1,524,019	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	173,875	67.00
68.00	06800	SPEECH PATHOLOGY	0	59,145	68.00
69.00	06900	ELECTROCARDIOLOGY	0	286,886	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44,774	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	279,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,249,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-156,551	2,459,338	73.00
76.00	03020	SONOGRAPHY	0	653,893	76.00
76.01	03040	AUDIOLOGY	0	270,210	76.01
76.02	03160	CARDIAC REHAB	0	87,691	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	188,184	88.00
90.00	09000	CLINIC	-9,079,308	11,283,778	90.00
91.00	09100	EMERGENCY	-755,402	1,656,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	976,504	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	923,564	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-20,033,279	77,451,484	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	36,772	194.00
194.01	07951	OTHER	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	194.02
194.03	07953	MANAGED CARE	0	51,184	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	2,235	194.05
194.06	07956	CHHW	0	360,420	194.06
194.08	07958	ENT	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	644,702	194.09
194.10	07960	PERU MALL	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	194.13
194.14	07964	HENRY	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.19	07969	GRANVILLE CLINIC	0	0	194.19
194.20	07970	PARATRANSIT	0	150,445	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	590,198	194.21
194.24	07974	SURGICAL ASSOCIATES	0	234	194.24
194.27	07977	MIDTOWN	0	0	194.27
194.28	07978	PAIN CLINIC	0	288,376	194.28
194.30	07980	WHC-PTON	0	0	194.30
194.31	07981	CFH	0	0	194.31
194.32	07982	PFS	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	-20,033,279	79,576,050	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet Non-CMS W Date/Time Prepared: 5/23/2022 11:01 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	00101		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	00201		2.01
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	MRI	05402		54.01
57.00	CT SCAN	05700		57.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	SONOGRAPHY	03020	ACUPUNCTURE	76.00
76.01	AUDIOLOGY	03040	AUDIOLOGY	76.01
76.02	CARDIAC REHAB	03160	CARDIOPULMONARY	76.02
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	04040	FAMILY PRACTICE	93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
114.00	UTILIZATION REVIEW-SNF	11400		114.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	CONGREGATE LIVING	07950		194.00
194.01	OTHER	07951		194.01
194.02	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	07952		194.02
194.03	MANAGED CARE	07953		194.03
194.04	RENTAL AREA/PPOS	07954		194.04
194.05	SPECIALTY CLINICS	07955		194.05
194.06	CHHW	07956		194.06
194.08	ENT	07958		194.08
194.09	DURABLE MEDICAL EQUIPMENT	07959		194.09
194.10	PERU MALL	07960		194.10
194.12	FAMILY ORTHOPEDIC CENTER	07962		194.12
194.13	WOMEN'S HEALTH CENTER	07963		194.13
194.14	HENRY	07964		194.14
194.16	SPRING VALLEY CLINIC	07966		194.16
194.17	OGLESBY MP OB	07967		194.17

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0143

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

Worksheet Non-CMS W

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
194.18	FAMILY HEALTH CENTER	07968		194.18
194.19	GRANVILLE CLINIC	07969		194.19
194.20	PARATRANSIT	07970		194.20
194.21	OCCUPATIONAL HEALTH	07971		194.21
194.24	SURGICAL ASSOCIATES	07974		194.24
194.27	MIDTOWN	07977		194.27
194.28	PAIN CLINIC	07978		194.28
194.30	WHC-PTON	07980		194.30
194.31	CFH	07981		194.31
194.32	PFS	07982		194.32
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - DIETARY RECLASS				
1.00	CAFETERIA	11.00	621,824	305,485	1.00
	TOTALS		621,824	305,485	
	C - LAUNDRY SALARIES				
1.00	LAUNDRY & LINEN SERVICE	8.00	53,466	0	1.00
	TOTALS		53,466	0	
	D - DEPRECIATION FOR OFF CAMPUS CLINICS				
1.00	CLINIC	90.00	0	1,238,047	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	1,238,047	
	E - AUDIOLOGY COSTS				
1.00	AUDIOLOGY	76.01	0	270,210	1.00
	TOTALS		0	270,210	
	F - INTEREST EXPENSE ON EQUIPMENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	214,958	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	13,122	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	791,889	3.00
	TOTALS		0	1,019,969	
	G - PARATRANSIT COSTS				
1.00	PARATRANSIT	194.20	121,251	29,194	1.00
	TOTALS		121,251	29,194	
	H - LABOR AND DELIVERY SALARIES				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	74,750	0	1.00
	TOTALS		74,750	0	
	I - TO RECLASS EMPLOYED HOSPITALIST				
1.00	ADULTS & PEDIATRICS	30.00	763,808	0	1.00
	TOTALS		763,808	0	
	J - RHC EXPENSES				
1.00	RURAL HEALTH CLINIC	88.00	143,102	45,082	1.00
	TOTALS		143,102	45,082	
500.00	Grand Total: Increases		1,778,201	2,907,987	500.00

RECLASSIFICATIONS

Provider CCN: 14-0143

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

Worksheet A-6

Date/Time Prepared:
5/23/2022 11:01 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	B - DIETARY RECLASS						1.00
	DIETARY	10.00	621,824	305,485	0		
	TOTALS		621,824	305,485			
1.00	C - LAUNDRY SALARIES						1.00
	HOUSEKEEPING	9.00	53,466	0	0		
	TOTALS		53,466	0			
1.00	D - DEPRECIATION FOR OFF CAMPUS CLINICS						1.00
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,238,047	9		
		0.00	0	0	9		
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,238,047			
1.00	E - AUDIOLOGY COSTS						1.00
	CLINIC	90.00	0	270,210	0		
	TOTALS		0	270,210			
1.00	F - INTEREST EXPENSE ON EQUIPMENT						1.00
	INTEREST EXPENSE	113.00	0	1,019,969	11		
		0.00	0	0	11		
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,019,969			
1.00	G - PARATRANSIT COSTS						1.00
	ADMINISTRATIVE & GENERAL	5.00	121,251	29,194	0		
	TOTALS		121,251	29,194			
1.00	H - LABOR AND DELIVERY SALARIES						1.00
	ADULTS & PEDIATRICS	30.00	74,750	0	0		
	TOTALS		74,750	0			
1.00	I - TO RECLASS EMPLOYED HOSPITALIST						1.00
	ADULTS & PEDIATRICS	30.00	0	763,808	0		
	TOTALS		0	763,808			
1.00	J - RHC EXPENSES						1.00
	CLINIC	90.00	143,102	45,082	0		
	TOTALS		143,102	45,082			
500.00	Grand Total: Decreases			1,014,393	3,671,795		500.00

RECLASSIFICATIONS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/23/2022 11:01 am

Increases					Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
	B - DIETARY RECLASS									
1.00	CAFETERIA	11.00	621,824	305,485	DIETARY	10.00	621,824	305,485		1.00
	TOTALS		621,824	305,485	TOTALS		621,824	305,485		
	C - LAUNDRY SALARIES									
1.00	LAUNDRY & LINEN SERVICE	8.00	53,466	0	HOUSEKEEPING	9.00	53,466	0		1.00
	TOTALS		53,466	0	TOTALS		53,466	0		
	D - DEPRECIATION FOR OFF CAMPUS CLINICS									
1.00	CLINIC	90.00	0	1,238,047	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,238,047		1.00
	TOTALS		0	1,238,047	TOTALS		0	1,238,047		
	E - AUDIOLOGY COSTS									
1.00	AUDIOLOGY	76.01	0	270,210	CLINIC	90.00	0	270,210		1.00
	TOTALS		0	270,210	TOTALS		0	270,210		
	F - INTEREST EXPENSE ON EQUIPMENT									
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	214,958	INTEREST EXPENSE	113.00	0	1,019,969		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	13,122		0.00	0	0		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	791,889		0.00	0	0		3.00
	TOTALS		0	1,019,969	TOTALS		0	1,019,969		
	G - PARATRANSIT COSTS									
1.00	PARATRANSIT	194.20	121,251	29,194	ADMINISTRATIVE & GENERAL	5.00	121,251	29,194		1.00
	TOTALS		121,251	29,194	TOTALS		121,251	29,194		
	H - LABOR AND DELIVERY SALARIES									
1.00	DELIVERY ROOM & LABOR ROOM	52.00	74,750	0	ADULTS & PEDIATRICS	30.00	74,750	0		1.00
	TOTALS		74,750	0	TOTALS		74,750	0		
	I - TO RECLASS EMPLOYED HOSPITALIST									
1.00	ADULTS & PEDIATRICS	30.00	763,808	0	ADULTS & PEDIATRICS	30.00	0	763,808		1.00
	TOTALS		763,808	0	TOTALS		0	763,808		
	J - RHC EXPENSES									
1.00	RURAL HEALTH CLINIC	88.00	143,102	45,082	CLINIC	90.00	143,102	45,082		1.00
	TOTALS		143,102	45,082	TOTALS		143,102	45,082		
500.00	Grand Total:		1,778,201	2,907,987	Grand Total:		1,014,393	3,671,795		500.00
	Increases				Decreases					

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
5/23/2022 11:01 am

		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	2,841,557	0	0	0	0	1.00
2.00	Land Improvements	3,242,104	0	0	0	0	2.00
3.00	Buildings and Fixtures	75,551,157	2,152,367	0	2,152,367	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	33,375,374	2,106,968	0	2,106,968	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	115,010,192	4,259,335	0	4,259,335	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	115,010,192	4,259,335	0	4,259,335	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,841,557	0				1.00
2.00	Land Improvements	3,242,104	0				2.00
3.00	Buildings and Fixtures	77,703,524	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	35,482,342	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	119,269,527	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	119,269,527	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,698,078	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,523,414	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	6,221,492	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,698,078				1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,523,414				2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	6,221,492				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	83,855,287	0	83,855,287	0.702673	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	35,482,342	0	35,482,342	0.297327	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	119,337,629	0	119,337,629	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,460,031	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,530,407	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,990,438	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	773,975	0	0	0	3,234,006	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	210,095	0	0	0	2,740,502	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	984,070	0	0	0	5,974,508	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-17,914	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-4,863	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-297	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-9,215	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,854	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-13,816,400			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	82,159			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-191,677	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-156,551	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,330	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	26.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A-8-3		0NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP		0OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	27.01	
28.00	Non-physician Anesthetist		0*** Cost Center Deleted ***	19.00		28.00	
29.00	Physicians' assistant		0	0.00	0	29.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		0OCCUPATIONAL THERAPY	67.00		30.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY)			0	0.00	0	33.00
33.01	OUTSIDE PT	B	-2,088	PHYSICAL THERAPY	66.00	0	33.01
33.02	PATIENT PHONES	A	-14,852	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONES DEPR	A	-174	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04	MISC INCOME	B	-990	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PHYSICIAN RECRUITMENT	A	-57,500	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	EMPLOYEE HEALTH	A	-835,025	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	ADMIN COSTS FOR POB	A	-1,011	ADMINISTRATIVE & GENERAL	5.00	9	33.07
33.08	LOBBYING PORTION OF DUES	A	-49,465	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HOSPITALISTS STAFF	A	-80,083	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	QUALITY REVENUE	B	-67,521	NURSING ADMINISTRATION	13.00	0	33.10
33.11	NON ALLOWABLE EXPENSE	A	-1,690,000	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ADMIN NONALLOWABLE	A	-1,075,756	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	INSURANCE PROCEEDS	B	-2,040,872	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,033,279				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2022 11:01 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,328,162	1,249,170 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000 2.00
3.00		2.00	NEW CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	66	0 3.00
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	7,101	0 4.00
5.00	0			0	1,335,329	1,253,170 5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2022 11:01 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	78,992	0		1.00
2.00	-4,000	0		2.00
3.00	66	9		3.00
4.00	7,101	9		4.00
5.00	82,159			5.00

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

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

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

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

6.00	RELIGIOUS COMMUNITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0143

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2022 11:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	16.00	MEDICAL RECORDS & LIBRARY	5,500	0	5,500	211,500	100	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,414,657	1,414,657	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	7,800	7,800	0	0	0	3.00
4.00	43.00	NURSERY	108,950	108,950	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,851,000	1,851,000	0	0	0	5.00
6.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	6.00
7.00	90.00	CLINIC	9,079,308	9,079,308	0	0	0	7.00
8.00	91.00	EMERGENCY	770,868	358,299	412,569	179,000	4,688	8.00
9.00	91.00	EMERGENCY	387,972	387,972	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	599,283	599,283	0	0	0	10.00
200.00			14,260,338	13,807,269	453,069		5,308	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	16.00	MEDICAL RECORDS & LIBRARY	10,168	508	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	65,075	3,254	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	403,438	20,172	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
200.00			478,681	23,934	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	16.00	MEDICAL RECORDS & LIBRARY	0	10,168	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,414,657		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	7,800		3.00
4.00	43.00	NURSERY	0	0	0	108,950		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,851,000		5.00
6.00	60.00	LABORATORY	0	65,075	0	0		6.00
7.00	90.00	CLINIC	0	0	0	9,079,308		7.00
8.00	91.00	EMERGENCY	0	403,438	9,131	367,430		8.00
9.00	91.00	EMERGENCY	0	0	0	387,972		9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	599,283		10.00
200.00			0	478,681	9,131	13,816,400		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,234,006	3,234,006				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	0	0			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,740,502			2,740,502		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	0			0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,584,958	11,232	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,684,021	1,167,101	0	642,450	0	5.00
7.00	00700	OPERATION OF PLANT	1,888,557	304,709	0	12,339	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	231,834	8,064	0	0	0	8.00
9.00	00900	HOUSEKEEPING	828,929	32,184	0	16,902	0	9.00
10.00	01000	DIETARY	324,116	80,049	0	22,135	0	10.00
11.00	01100	CAFETERIA	735,632	27,523	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,181,269	27,624	0	2,141	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,806,440	28,386	0	13,995	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,388,652	240,939	0	103,386	0	30.00
31.00	03100	INTENSIVE CARE UNIT	858,896	51,745	0	45,687	0	31.00
43.00	04300	NURSERY	78,028	12,400	0	25,899	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,839,554	279,075	0	573,351	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	380,729	6,246	0	21,807	0	52.00
53.00	05300	ANESTHESIOLOGY	167,187	4,682	0	43,680	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,133,002	81,400	0	573,744	0	54.00
54.01	05402	MRI	340,136	21,307	0	53,298	0	54.01
57.00	05700	CT SCAN	590,448	6,601	0	1,249	0	57.00
60.00	06000	LABORATORY	4,374,431	39,700	0	76,421	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	191,448	2,376	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	750,895	15,843	0	17,597	0	65.00
66.00	06600	PHYSICAL THERAPY	1,524,019	105,439	0	5,395	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	173,875	396	0	1,229	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,145	1,787	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	286,886	1,341	0	6,844	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,774	10,146	0	2,772	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,294	75,113	0	45,729	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,249,720	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,459,338	25,024	0	24,853	0	73.00
76.00	03020	SONOGRAPHY	653,893	5,433	0	16,789	0	76.00
76.01	03040	AUDIOLOGY	270,210	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	87,691	11,923	0	5,041	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	188,184	0	0	0	0	88.00
90.00	09000	CLINIC	11,283,778	181,223	0	293,086	0	90.00
91.00	09100	EMERGENCY	1,656,939	99,559	0	65,911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	976,504	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	923,564	9,892	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,451,484	2,976,462	0	2,713,730	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,558	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	36,772	0	0	0	0	194.00
194.01	07951	OTHER	0	134,810	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	51,184	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	79,724	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	2,235	0	0	895	0	194.05
194.06	07956	CHHW	360,420	0	0	0	0	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	644,702	29,452	0	21,360	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	150,445	0	0	2,638	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	590,198	0	0	1,879	0	194.21
194.24	07974	SURGICAL ASSOCIATES	234	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	288,376	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,576,050	3,234,006	0	2,740,502	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,596,190					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	833,223	17,326,795	17,326,795			5.00
7.00	00700	OPERATION OF PLANT	140,259	2,345,864	652,960	2,998,824		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,210	254,108	70,730	13,811	338,649	8.00
9.00	00900	HOUSEKEEPING	153,486	1,031,501	287,113	55,121	0	9.00
10.00	01000	DIETARY	57,764	484,064	134,737	137,098	0	10.00
11.00	01100	CAFETERIA	165,263	928,418	258,421	47,137	0	11.00
13.00	01300	NURSING ADMINISTRATION	303,569	1,514,603	421,582	47,311	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	377,089	2,225,910	619,571	48,616	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	693,895	4,426,872	1,232,198	412,650	220,237	30.00
31.00	03100	INTENSIVE CARE UNIT	191,222	1,147,550	319,415	88,621	18,049	31.00
43.00	04300	NURSERY	14,297	130,624	36,359	21,238	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	551,145	7,243,125	2,016,088	477,963	35,897	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82,676	491,458	136,795	10,697	0	52.00
53.00	05300	ANESTHESIOLOGY	0	215,549	59,997	8,019	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	218,628	3,006,774	836,921	139,411	22,588	54.00
54.01	05402	MRI	41,228	455,969	126,917	36,492	0	54.01
57.00	05700	CT SCAN	37,339	635,637	176,926	11,306	4,504	57.00
60.00	06000	LABORATORY	301,946	4,792,498	1,333,968	67,992	169	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	193,824	53,950	4,070	0	63.00
65.00	06500	RESPIRATORY THERAPY	99,591	883,926	246,036	27,134	661	65.00
66.00	06600	PHYSICAL THERAPY	380,555	2,015,408	560,979	180,582	18,049	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,847	220,347	61,332	678	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,482	74,414	20,713	3,061	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,806	319,877	89,036	2,296	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,062	68,754	19,137	17,376	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,297	412,433	114,799	128,644	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,249,720	626,198	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,565	2,710,780	754,532	42,858	0	73.00
76.00	03020	SONOGRAPHY	48,505	724,620	201,694	9,306	0	76.00
76.01	03040	AUDIOLOGY	0	270,210	75,212	0	0	76.01
76.02	03160	CARDIAC REHAB	20,789	125,444	34,917	20,420	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	38,033	226,217	62,966	0	0	88.00
90.00	09000	CLINIC	1,821,320	13,579,407	3,779,783	310,374	0	90.00
91.00	09100	EMERGENCY	263,081	2,085,490	580,486	170,511	18,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	976,504	271,805	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	131,903	1,065,359	296,537	16,942	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,289,075	76,860,053	16,570,810	2,557,735	338,203	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,558	3,774	23,221	0	190.00
194.00	07950	CONGREGATE LIVING	0	36,772	10,235	0	0	194.00
194.01	07951	OTHER	9,136	143,946	40,067	230,885	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	9,714	60,898	16,951	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	79,724	22,191	136,541	0	194.04
194.05	07955	SPECIALTY CLINICS	0	3,130	871	0	446	194.05
194.06	07956	CHHW	17,396	377,816	105,163	0	0	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	59,699	755,213	210,210	50,442	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
194.20	07970	PARATRANSIT	32,225	185,308	51,580	0	0 194.20
194.21	07971	OCCUPATIONAL HEALTH	140,567	732,644	203,928	0	0 194.21
194.24	07974	SURGICAL ASSOCIATES	0	234	65	0	0 194.24
194.27	07977	MIDTOWN	0	0	0	0	0 194.27
194.28	07978	PAIN CLINIC	38,378	326,754	90,950	0	0 194.28
194.30	07980	WHC-PTON	0	0	0	0	0 194.30
194.31	07981	CFH	0	0	0	0	0 194.31
194.32	07982	PFS	0	0	0	0	0 194.32
200.00		Cross Foot Adjustments	0	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)	7,596,190	79,576,050	17,326,795	2,998,824	338,649 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,373,735					9.00
10.00	01000	DIETARY	68,203	824,102				10.00
11.00	01100	CAFETERIA	54,418	0	1,288,394			11.00
13.00	01300	NURSING ADMINISTRATION	40,896	0	71,218	2,095,610		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,528	0	150,458	0	3,126,083	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	526,047	473,091	243,414	871,209	130,267	30.00
31.00	03100	INTENSIVE CARE UNIT	67,644	123,472	54,190	207,171	30,584	31.00
43.00	04300	NURSERY	6,218	0	7,039	26,912	7,661	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	109,362	0	163,191	623,873	481,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,406	0	21,893	83,694	13,886	52.00
53.00	05300	ANESTHESIOLOGY	1,119	0	0	0	116,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,632	0	76,497	0	150,000	54.00
54.01	05402	MRI	2,468	0	7,091	0	98,625	54.01
57.00	05700	CT SCAN	2,468	0	11,542	0	208,749	57.00
60.00	06000	LABORATORY	27,373	0	109,881	0	596,688	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,895	0	0	0	4,585	63.00
65.00	06500	RESPIRATORY THERAPY	6,613	0	29,088	0	49,991	65.00
66.00	06600	PHYSICAL THERAPY	13,621	0	0	0	147,303	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	17,582	67.00
68.00	06800	SPEECH PATHOLOGY	2,468	0	0	0	3,725	68.00
69.00	06900	ELECTROCARDIOLOGY	4,277	0	7,712	0	89,087	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	987	0	4,399	0	4,874	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,613	0	7,246	0	162,945	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	47,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,373	0	45,236	0	104,364	73.00
76.00	03020	SONOGRAPHY	2,468	0	0	0	109,574	76.00
76.01	03040	AUDIOLOGY	2,468	0	11,594	0	7,309	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	11,434	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,530	88.00
90.00	09000	CLINIC	0	0	143,212	0	68,722	90.00
91.00	09100	EMERGENCY	27,373	0	73,961	282,751	143,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	12,828	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	23,856	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,152,938	596,563	1,238,862	2,095,610	2,846,365	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,468	69,480	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00
194.01	07951	OTHER	0	158,059	0	0	263,374	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	2,329	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	218,329	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	0	194.05
194.06	07956	CHHW	0	0	0	0	0	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	7,535	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
194.20	07970 PARATRANSIT	0	0	19,875	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	0	11,956	0	4,275	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977 MIDTOWN	0	0	0	0	0	194.27
194.28	07978 PAIN CLINIC	0	0	15,372	0	4,534	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	0	0	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,373,735	824,102	1,288,394	2,095,610	3,126,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	8,535,985	-995,029	7,540,956	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,056,696	0	2,056,696	31.00
43.00	04300	NURSERY	0	236,051	0	236,051	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,150,804	0	11,150,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	785,829	0	785,829	52.00
53.00	05300	ANESTHESIOLOGY	0	400,749	0	400,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,272,823	0	4,272,823	54.00
54.01	05402	MRI	0	727,562	0	727,562	54.01
57.00	05700	CT SCAN	0	1,051,132	0	1,051,132	57.00
60.00	06000	LABORATORY	0	6,928,569	0	6,928,569	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	259,324	0	259,324	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,243,449	0	1,243,449	65.00
66.00	06600	PHYSICAL THERAPY	0	2,935,942	0	2,935,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	299,939	0	299,939	67.00
68.00	06800	SPEECH PATHOLOGY	0	104,381	0	104,381	68.00
69.00	06900	ELECTROCARDIOLOGY	0	512,285	0	512,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	115,527	0	115,527	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	832,680	873,004	1,705,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,923,731	0	2,923,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,685,143	0	3,685,143	73.00
76.00	03020	SONOGRAPHY	0	1,047,662	122,025	1,169,687	76.00
76.01	03040	AUDIOLOGY	0	366,793	0	366,793	76.01
76.02	03160	CARDIAC REHAB	0	192,215	0	192,215	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	292,713	0	292,713	88.00
90.00	09000	CLINIC	0	17,881,498	0	17,881,498	90.00
91.00	09100	EMERGENCY	0	3,381,634	0	3,381,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,261,137	0	1,261,137	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,402,694	0	1,402,694	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	74,884,947	0	74,884,947	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	112,501	0	112,501	190.00
194.00	07950	CONGREGATE LIVING	0	47,007	0	47,007	194.00
194.01	07951	OTHER	0	836,331	0	836,331	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	80,178	0	80,178	194.03
194.04	07954	RENTAL AREA/PPOS	0	456,785	0	456,785	194.04
194.05	07955	SPECIALTY CLINICS	0	4,447	0	4,447	194.05
194.06	07956	CHHW	0	482,979	0	482,979	194.06
194.08	07958	ENT	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	1,023,400	0	1,023,400	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	194.17

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0		194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0		194.19
194.20	07970	PARATRANSIT	0	256,763	0	256,763		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	952,803	0	952,803		194.21
194.24	07974	SURGICAL ASSOCIATES	0	299	0	299		194.24
194.27	07977	MIDTOWN	0	0	0	0		194.27
194.28	07978	PAIN CLINIC	0	437,610	0	437,610		194.28
194.30	07980	WHC-PTON	0	0	0	0		194.30
194.31	07981	CFH	0	0	0	0		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	79,576,050	0	79,576,050		202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0143

Period:

From 10/01/2020

To 09/30/2021

Worksheet Non-CMS W

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR	VALUE	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR	VALUE	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS	SALARY	4.00
5.00	ADMINISTRATIVE & GENERAL	-16	ACCUM.	COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF	SERVICE	9.00
10.00	DIETARY	10	MEALS	SERVED	10.00
11.00	CAFETERIA	11	FTE'S		11.00
13.00	NURSING ADMINISTRATION	13	HOURS OF	SERVICE	13.00
16.00	MEDICAL RECORDS & LIBRARY	14	PATIENT	CHARGES	16.00
17.00	SOCIAL SERVICE	15	TIME	SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP		
			0	1.00	1.01	2.00	2.01		
	GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00	
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00	
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,232	0	0	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	15,824	1,167,101	0	642,450	0	5.00	
7.00	00700	OPERATION OF PLANT	3,993	304,709	0	12,339	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,064	0	0	0	8.00	
9.00	00900	HOUSEKEEPING	1,870	32,184	0	16,902	0	9.00	
10.00	01000	DIETARY	0	80,049	0	22,135	0	10.00	
11.00	01100	CAFETERIA	0	27,523	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	27,624	0	2,141	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,206	28,386	0	13,995	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,334	240,939	0	103,386	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	8,299	51,745	0	45,687	0	31.00	
43.00	04300	NURSERY	0	12,400	0	25,899	0	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	160,626	279,075	0	573,351	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,246	0	21,807	0	52.00	
53.00	05300	ANESTHESIOLOGY	31,786	4,682	0	43,680	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,336	81,400	0	573,744	0	54.00	
54.01	05402	MRI	0	21,307	0	53,298	0	54.01	
57.00	05700	CT SCAN	146,853	6,601	0	1,249	0	57.00	
60.00	06000	LABORATORY	0	39,700	0	76,421	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,376	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	10,117	15,843	0	17,597	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	105,439	0	5,395	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	396	0	1,229	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	1,787	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	1,341	0	6,844	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,146	0	2,772	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,113	0	45,729	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	506	25,024	0	24,853	0	73.00	
76.00	03020	SONOGRAPHY	0	5,433	0	16,789	0	76.00	
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01	
76.02	03160	CARDIAC REHAB	0	11,923	0	5,041	0	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
90.00	09000	CLINIC	351	181,223	0	293,086	0	90.00	
91.00	09100	EMERGENCY	9,733	99,559	0	65,911	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	29,712	9,892	0	0	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	471,546	2,976,462	0	2,713,730	0	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,558	0	0	0	190.00	
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00	
194.01	07951	OTHER	0	134,810	0	0	0	194.01	
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02	
194.03	07953	MANAGED CARE	0	0	0	0	0	194.03	
194.04	07954	RENTAL AREA/PP0S	0	79,724	0	0	0	194.04	
194.05	07955	SPECIALTY CLINICS	0	0	0	895	0	194.05	
194.06	07956	CHHW	0	0	0	0	0	194.06	
194.08	07958	ENT	0	0	0	0	0	194.08	
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	29,452	0	21,360	0	194.09	
194.10	07960	PERU MALL	0	0	0	0	0	194.10	
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12	
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13	
194.14	07964	HENRY	0	0	0	0	0	194.14	
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	2,638	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	4,066	0	0	1,879	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	2,674	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	478,286	3,234,006	0	2,740,502	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,232	11,232				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,825,375	1,232	1,826,607			5.00
7.00	00700	OPERATION OF PLANT	321,041	207	68,835	390,083		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,064	21	7,456	1,796	17,337	8.00
9.00	00900	HOUSEKEEPING	50,956	227	30,267	7,170	0	9.00
10.00	01000	DIETARY	102,184	85	14,204	17,833	0	10.00
11.00	01100	CAFETERIA	27,523	244	27,243	6,132	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,765	449	44,443	6,154	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,587	558	65,315	6,324	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	384,659	1,026	129,898	53,677	11,274	30.00
31.00	03100	INTENSIVE CARE UNIT	105,731	283	33,673	11,528	924	31.00
43.00	04300	NURSERY	38,299	21	3,833	2,763	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,013,052	815	212,535	62,174	1,838	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,053	122	14,421	1,391	0	52.00
53.00	05300	ANESTHESIOLOGY	80,148	0	6,325	1,043	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	665,480	323	88,228	18,134	1,156	54.00
54.01	05402	MRI	74,605	61	13,379	4,747	0	54.01
57.00	05700	CT SCAN	154,703	55	18,651	1,471	231	57.00
60.00	06000	LABORATORY	116,121	446	140,626	8,844	9	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,376	0	5,687	529	0	63.00
65.00	06500	RESPIRATORY THERAPY	43,557	147	25,937	3,530	34	65.00
66.00	06600	PHYSICAL THERAPY	110,834	563	59,138	23,490	924	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,625	66	6,466	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,787	20	2,184	398	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,185	37	9,386	299	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,918	16	2,017	2,260	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,842	18	12,102	16,734	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	66,014	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,383	298	79,542	5,575	0	73.00
76.00	03020	SONOGRAPHY	22,222	72	21,263	1,210	0	76.00
76.01	03040	AUDIOLOGY	0	0	7,929	0	0	76.01
76.02	03160	CARDIAC REHAB	16,964	31	3,681	2,656	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	56	6,638	0	0	88.00
90.00	09000	CLINIC	474,660	2,694	398,486	40,373	0	90.00
91.00	09100	EMERGENCY	175,203	389	61,195	22,180	924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	28,654	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	39,604	195	31,261	2,204	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,161,738	10,777	1,746,912	332,707	17,314	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,558	0	398	3,021	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	1,079	0	0	194.00
194.01	07951	OTHER	134,810	14	4,224	30,033	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	14	1,787	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	79,724	0	2,339	17,761	0	194.04
194.05	07955	SPECIALTY CLINICS	895	0	92	0	23	194.05
194.06	07956	CHHW	0	26	11,086	0	0	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	50,812	88	22,160	6,561	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
194.20	07970	PARATRANSIT	2,638	48	5,437	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	5,945	208	21,498	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	7	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	2,674	57	9,588	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,452,794	11,232	1,826,607	390,083	17,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	88,620					9.00
10.00	01000	DIETARY	4,400	138,706				10.00
11.00	01100	CAFETERIA	3,511	0	64,653			11.00
13.00	01300	NURSING ADMINISTRATION	2,638	0	3,574	87,023		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,259	0	7,550	0	128,593	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,935	79,627	12,214	36,177	5,358	30.00
31.00	03100	INTENSIVE CARE UNIT	4,364	20,782	2,719	8,603	1,258	31.00
43.00	04300	NURSERY	401	0	353	1,118	315	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,055	0	8,189	25,907	19,798	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,768	0	1,099	3,476	571	52.00
53.00	05300	ANESTHESIOLOGY	72	0	0	0	4,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,621	0	3,839	0	6,170	54.00
54.01	05402	MRI	159	0	356	0	4,057	54.01
57.00	05700	CT SCAN	159	0	579	0	8,587	57.00
60.00	06000	LABORATORY	1,766	0	5,514	0	24,548	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	187	0	0	0	189	63.00
65.00	06500	RESPIRATORY THERAPY	427	0	1,460	0	2,056	65.00
66.00	06600	PHYSICAL THERAPY	879	0	0	0	6,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	723	67.00
68.00	06800	SPEECH PATHOLOGY	159	0	0	0	153	68.00
69.00	06900	ELECTROCARDIOLOGY	276	0	387	0	3,665	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64	0	221	0	200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	427	0	364	0	6,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766	0	2,270	0	4,293	73.00
76.00	03020	SONOGRAPHY	159	0	0	0	4,507	76.00
76.01	03040	AUDIOLOGY	159	0	582	0	301	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	470	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	145	88.00
90.00	09000	CLINIC	0	0	7,187	0	2,827	90.00
91.00	09100	EMERGENCY	1,766	0	3,711	11,742	5,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	528	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	981	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,377	100,409	62,168	87,023	117,086	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	159	11,694	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00
194.01	07951	OTHER	0	26,603	0	0	10,834	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	117	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	14,084	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	0	194.05
194.06	07956	CHHW	0	0	0	0	0	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	310	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
194.20	07970 PARATRANSIT	0	0	997	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	0	600	0	176	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977 MIDTOWN	0	0	0	0	0	194.27
194.28	07978 PAIN CLINIC	0	0	771	0	187	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	0	0	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	88,620	138,706	64,653	87,023	128,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	747,845	0	747,845	30.00
31.00	03100	INTENSIVE CARE UNIT	0	189,865	0	189,865	31.00
43.00	04300	NURSERY	0	47,103	0	47,103	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,351,363	0	1,351,363	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,901	0	50,901	52.00
53.00	05300	ANESTHESIOLOGY	0	92,362	0	92,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	785,951	0	785,951	54.00
54.01	05402	MRI	0	97,364	0	97,364	54.01
57.00	05700	CT SCAN	0	184,436	0	184,436	57.00
60.00	06000	LABORATORY	0	297,874	0	297,874	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,968	0	8,968	63.00
65.00	06500	RESPIRATORY THERAPY	0	77,148	0	77,148	65.00
66.00	06600	PHYSICAL THERAPY	0	201,887	0	201,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,968	0	8,968	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,701	0	4,701	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,235	0	22,235	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,696	0	17,696	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	157,190	0	157,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,981	0	67,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	144,127	0	144,127	73.00
76.00	03020	SONOGRAPHY	0	49,433	0	49,433	76.00
76.01	03040	AUDIOLOGY	0	8,971	0	8,971	76.01
76.02	03160	CARDIAC REHAB	0	23,802	0	23,802	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,839	0	6,839	88.00
90.00	09000	CLINIC	0	926,227	0	926,227	90.00
91.00	09100	EMERGENCY	0	282,993	0	282,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	29,182	0	29,182	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	74,245	0	74,245	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,957,657	0	5,957,657	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,830	0	28,830	190.00
194.00	07950	CONGREGATE LIVING	0	1,079	0	1,079	194.00
194.01	07951	OTHER	0	206,518	0	206,518	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	1,918	0	1,918	194.03
194.04	07954	RENTAL AREA/PPOS	0	113,908	0	113,908	194.04
194.05	07955	SPECIALTY CLINICS	0	1,010	0	1,010	194.05
194.06	07956	CHHW	0	11,112	0	11,112	194.06
194.08	07958	ENT	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	79,931	0	79,931	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0		194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0		194.19
194.20	07970	PARATRANSIT	0	9,120	0	9,120		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	28,427	0	28,427		194.21
194.24	07974	SURGICAL ASSOCIATES	0	7	0	7		194.24
194.27	07977	MIDTOWN	0	0	0	0		194.27
194.28	07978	PAIN CLINIC	0	13,277	0	13,277		194.28
194.30	07980	WHC-PTON	0	0	0	0		194.30
194.31	07981	CFH	0	0	0	0		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,452,794	0	6,452,794		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)		
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00	2.01			4.00
	GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	318,435					1.00	
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	318,435				1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,523,414			2.00	
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	95		2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	0	28,581,588	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	114,918	114,918	591,559	95	3,135,106	5.00	
7.00	00700	OPERATION OF PLANT	30,003	30,003	11,362	0	527,742	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	53,466	8.00	
9.00	00900	HOUSEKEEPING	3,169	3,169	15,563	0	577,509	9.00	
10.00	01000	DIETARY	7,882	7,882	20,382	0	217,345	10.00	
11.00	01100	CAFETERIA	2,710	2,710	0	0	621,824	11.00	
13.00	01300	NURSING ADMINISTRATION	2,720	2,720	1,971	0	1,142,216	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,795	2,795	12,886	0	1,418,845	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,724	23,724	95,196	0	2,610,864	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	42,068	0	719,495	31.00	
43.00	04300	NURSERY	1,221	1,221	23,847	0	53,795	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,479	27,479	527,933	0	2,073,752	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	20,080	0	311,079	52.00	
53.00	05300	ANESTHESIOLOGY	461	461	40,220	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	528,295	0	822,614	54.00	
54.01	05402	MRI	2,098	2,098	49,076	0	155,124	54.01	
57.00	05700	CT SCAN	650	650	1,150	0	140,493	57.00	
60.00	06000	LABORATORY	3,909	3,909	70,367	0	1,136,110	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	1,560	1,560	16,203	0	374,724	65.00	
66.00	06600	PHYSICAL THERAPY	10,382	10,382	4,968	0	1,431,884	66.00	
67.00	06700	OCCUPATIONAL THERAPY	39	39	1,132	0	168,744	67.00	
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	50,728	68.00	
69.00	06900	ELECTROCARDIOLOGY	132	132	6,302	0	93,336	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	999	999	2,552	0	41,621	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,396	7,396	42,107	0	46,270	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,464	2,464	22,884	0	758,415	73.00	
76.00	03020	SONOGRAPHY	535	535	15,459	0	182,505	76.00	
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01	
76.02	03160	CARDIAC REHAB	1,174	1,174	4,642	0	78,222	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	143,102	88.00	
90.00	09000	CLINIC	17,844	17,844	269,869	0	6,852,919	90.00	
91.00	09100	EMERGENCY	9,803	9,803	60,690	0	989,876	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	974	974	0	0	496,302	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,076	293,076	2,498,763	95	27,426,027	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	0	190.00	
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00	
194.01	07951	OTHER	13,274	13,274	0	0	34,377	194.01	
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02	
194.03	07953	MANAGED CARE	0	0	0	0	36,550	194.03	
194.04	07954	RENTAL AREA/PPOS	7,850	7,850	0	0	0	194.04	
194.05	07955	SPECIALTY CLINICS	0	0	824	0	0	194.05	
194.06	07956	CHHW	0	0	0	0	65,456	194.06	
194.08	07958	ENT	0	0	0	0	0	194.08	
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	19,668	0	224,626	194.09	
194.10	07960	PERU MALL	0	0	0	0	0	194.10	
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12	
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13	
194.14	07964	HENRY	0	0	0	0	0	194.14	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	2,429	0	121,251	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	1,730	0	528,899	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	144,402	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,234,006	0	2,740,502	0	7,596,190	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.155938	0.000000	1.086029	0.000000	0.265772	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					11,232	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000393	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-17,326,795	62,249,255			5.00
7.00	00700	OPERATION OF PLANT	0	2,345,864	172,408		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,108	794	267,945	8.00
9.00	00900	HOUSEKEEPING	0	1,031,501	3,169	0	41,754 9.00
10.00	01000	DIETARY	0	484,064	7,882	0	2,073 10.00
11.00	01100	CAFETERIA	0	928,418	2,710	0	1,654 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,514,603	2,720	0	1,243 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,225,910	2,795	0	2,478 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,426,872	23,724	174,254	15,989 30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,147,550	5,095	14,281	2,056 31.00
43.00	04300	NURSERY	0	130,624	1,221	0	189 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,243,125	27,479	28,402	3,324 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	491,458	615	0	833 52.00
53.00	05300	ANESTHESIOLOGY	0	215,549	461	0	34 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,006,774	8,015	17,872	1,235 54.00
54.01	05402	MRI	0	455,969	2,098	0	75 54.01
57.00	05700	CT SCAN	0	635,637	650	3,564	75 57.00
60.00	06000	LABORATORY	0	4,792,498	3,909	134	832 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	193,824	234	0	88 63.00
65.00	06500	RESPIRATORY THERAPY	0	883,926	1,560	523	201 65.00
66.00	06600	PHYSICAL THERAPY	0	2,015,408	10,382	14,281	414 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	220,347	39	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	74,414	176	0	75 68.00
69.00	06900	ELECTROCARDIOLOGY	0	319,877	132	0	130 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	68,754	999	0	30 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	412,433	7,396	0	201 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,249,720	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,710,780	2,464	0	832 73.00
76.00	03020	SONOGRAPHY	0	724,620	535	0	75 76.00
76.01	03040	AUDIOLOGY	0	270,210	0	0	75 76.01
76.02	03160	CARDIAC REHAB	0	125,444	1,174	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	226,217	0	0	0 88.00
90.00	09000	CLINIC	0	13,579,407	17,844	0	0 90.00
91.00	09100	EMERGENCY	0	2,085,490	9,803	14,281	832 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	976,504	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,065,359	974	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,326,795	59,533,258	147,049	267,592	35,043 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,558	1,335	0	75 190.00
194.00	07950	CONGREGATE LIVING	0	36,772	0	0	0 194.00
194.01	07951	OTHER	0	143,946	13,274	0	0 194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0 194.02
194.03	07953	MANAGED CARE	0	60,898	0	0	0 194.03
194.04	07954	RENTAL AREA/PPOS	0	79,724	7,850	0	6,636 194.04
194.05	07955	SPECIALTY CLINICS	0	3,130	0	353	0 194.05
194.06	07956	CHHW	0	377,816	0	0	0 194.06
194.08	07958	ENT	0	0	0	0	0 194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	755,213	2,900	0	0 194.09
194.10	07960	PERU MALL	0	0	0	0	0 194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0 194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0 194.13
194.14	07964	HENRY	0	0	0	0	0 194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0 194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0 194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0 194.18

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	185,308	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	732,644	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	234	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	326,754	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		17,326,795	2,998,824	338,649	1,373,735	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.278345	17.393764	1.263875	32.900680	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,826,607	390,083	17,337	88,620	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.029343	2.262557	0.064704	2.122431	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:

5/23/2022 11:01 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	18,942					10.00
11.00	01100	CAFETERIA	0	24,893				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,376	220,292			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,907	0	252,626,794		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,874	4,703	91,582	10,527,448	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,838	1,047	21,778	2,471,604	0	31.00
43.00	04300	NURSERY	0	136	2,829	619,120	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,153	65,582	38,896,493	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	423	8,798	1,122,159	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,379,772	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,478	0	12,122,174	0	54.00
54.01	05402	MRI	0	137	0	7,970,328	0	54.01
57.00	05700	CT SCAN	0	223	0	16,869,999	0	57.00
60.00	06000	LABORATORY	0	2,123	0	48,214,810	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	370,553	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	562	0	4,040,041	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,904,275	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,420,921	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	301,041	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	149	0	7,199,537	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	85	0	393,899	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140	0	13,168,301	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,864,029	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	874	0	8,434,102	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	8,855,186	0	76.00
76.01	03040	AUDIOLOGY	0	224	0	590,648	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	923,998	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	285,272	0	88.00
90.00	09000	CLINIC	0	2,767	0	5,553,712	0	90.00
91.00	09100	EMERGENCY	0	1,429	29,723	11,557,500	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	1,036,685	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	1,927,901	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,712	23,936	220,292	230,021,508	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,597	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00
194.01	07951	OTHER	3,633	0	0	21,284,491	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	45	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	0	194.05
194.06	07956	CHHW	0	0	0	0	0	194.06
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	608,908	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
194.18	07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970 PARATRANSIT	0	384	0	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	231	0	345,472	0	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977 MIDTOWN	0	0	0	0	0	194.27
194.28	07978 PAIN CLINIC	0	297	0	366,415	0	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	0	0	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	824,102	1,288,394	2,095,610	3,126,083	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	43.506599	51.757281	9.512874	0.012374	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	138,706	64,653	87,023	128,593	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.322669	2.597236	0.395035	0.000509	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS

Provider CCN: 14-0143

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

Worksheet B-2

Date/Time Prepared:
5/23/2022 11:01 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		INFUSIONS		1	30.00	-873,004
8.00		INFUSIONS		1	71.00	873,004
9.00		INFUSIONS		1	30.00	-122,025
10.00		INFUSIONS		1	76.00	122,025

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/23/2022 11:01 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,540,956		7,540,956	0	7,540,956	30.00
31.00	03100	INTENSIVE CARE UNIT	2,056,696		2,056,696	0	2,056,696	31.00
43.00	04300	NURSERY	236,051		236,051	0	236,051	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,150,804		11,150,804	0	11,150,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	785,829		785,829	0	785,829	52.00
53.00	05300	ANESTHESIOLOGY	400,749		400,749	0	400,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,272,823		4,272,823	0	4,272,823	54.00
54.01	05402	MRI	727,562		727,562	0	727,562	54.01
57.00	05700	CT SCAN	1,051,132		1,051,132	0	1,051,132	57.00
60.00	06000	LABORATORY	6,928,569		6,928,569	0	6,928,569	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	259,324		259,324	0	259,324	63.00
65.00	06500	RESPIRATORY THERAPY	1,243,449	0	1,243,449	0	1,243,449	65.00
66.00	06600	PHYSICAL THERAPY	2,935,942	0	2,935,942	0	2,935,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,939	0	299,939	0	299,939	67.00
68.00	06800	SPEECH PATHOLOGY	104,381	0	104,381	0	104,381	68.00
69.00	06900	ELECTROCARDIOLOGY	512,285		512,285	0	512,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,527		115,527	0	115,527	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,705,684		1,705,684	0	1,705,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,923,731		2,923,731	0	2,923,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,685,143		3,685,143	0	3,685,143	73.00
76.00	03020	SONOGRAPHY	1,169,687		1,169,687	0	1,169,687	76.00
76.01	03040	AUDIOLOGY	366,793		366,793	0	366,793	76.01
76.02	03160	CARDIAC REHAB	192,215		192,215	0	192,215	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	292,713		292,713	0	292,713	88.00
90.00	09000	CLINIC	17,881,498		17,881,498	0	17,881,498	90.00
91.00	09100	EMERGENCY	3,381,634		3,381,634	9,131	3,390,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,651,597		1,651,597		1,651,597	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,261,137		1,261,137	0	1,261,137	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,402,694		1,402,694		1,402,694	116.00
200.00		Subtotal (see instructions)	76,536,544	0	76,536,544	9,131	76,545,675	200.00
201.00		Less Observation Beds	1,651,597		1,651,597		1,651,597	201.00
202.00		Total (see instructions)	74,884,947	0	74,884,947	9,131	74,894,078	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/23/2022 11:01 am

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,022,147		8,022,147		30.00
31.00	03100	INTENSIVE CARE UNIT	2,460,182		2,460,182		31.00
43.00	04300	NURSERY	612,731		612,731		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,311,099	31,222,985	38,534,084	0.289375	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,003,523	106,882	1,110,405	0.707696	0.000000
53.00	05300	ANESTHESIOLOGY	2,245,452	7,051,574	9,297,026	0.043105	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,479,907	10,574,876	12,054,783	0.354450	0.000000
54.01	05402	MRI	353,878	7,548,468	7,902,346	0.092069	0.000000
57.00	05700	CT SCAN	2,250,567	14,515,496	16,766,063	0.062694	0.000000
60.00	06000	LABORATORY	8,480,542	39,438,898	47,919,440	0.144588	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	208,581	161,083	369,664	0.701513	0.000000
65.00	06500	RESPIRATORY THERAPY	2,972,024	1,057,660	4,029,684	0.308572	0.000000
66.00	06600	PHYSICAL THERAPY	739,262	11,074,084	11,813,346	0.248528	0.000000
67.00	06700	OCCUPATIONAL THERAPY	130,929	1,279,375	1,410,304	0.212677	0.000000
68.00	06800	SPEECH PATHOLOGY	19,829	279,596	299,425	0.348605	0.000000
69.00	06900	ELECTROCARDIOLOGY	2,480,805	4,692,965	7,173,770	0.071411	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	1,916	387,928	389,844	0.296342	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,963,195	6,167,538	13,130,733	0.129900	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,220,809	1,643,220	3,864,029	0.756653	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	4,124,991	4,255,858	8,380,849	0.439710	0.000000
76.00	03020	SONOGRAPHY	1,180,031	7,623,888	8,803,919	0.132860	0.000000
76.01	03040	AUDIOLOGY	0	590,648	590,648	0.621001	0.000000
76.02	03160	CARDIAC REHAB	4,884	913,233	918,117	0.209358	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	285,272	285,272		88.00
90.00	09000	CLINIC	93,000	5,411,319	5,504,319	3.248630	0.000000
91.00	09100	EMERGENCY	1,758,311	9,740,515	11,498,826	0.294085	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	180,963	2,275,058	2,456,021	0.672469	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,859	1,026,414	1,032,273	1.221709	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,917,513	1,917,513		116.00
200.00		Subtotal (see instructions)	57,305,417	171,242,346	228,547,763		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	57,305,417	171,242,346	228,547,763		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 5/23/2022 11:01 am
			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
43.00	04300	NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289375		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707696		52.00
53.00	05300	ANESTHESIOLOGY	0.043105		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.354450		54.00
54.01	05402	MRI	0.092069		54.01
57.00	05700	CT SCAN	0.062694		57.00
60.00	06000	LABORATORY	0.144588		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.701513		63.00
65.00	06500	RESPIRATORY THERAPY	0.308572		65.00
66.00	06600	PHYSICAL THERAPY	0.248528		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212677		67.00
68.00	06800	SPEECH PATHOLOGY	0.348605		68.00
69.00	06900	ELECTROCARDIOLOGY	0.071411		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296342		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.129900		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.756653		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439710		73.00
76.00	03020	SONOGRAPHY	0.132860		76.00
76.01	03040	AUDIOLOGY	0.621001		76.01
76.02	03160	CARDIAC REHAB	0.209358		76.02
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	3.248630		90.00
91.00	09100	EMERGENCY	0.294879		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672469		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1.221709		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/23/2022 11:01 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
1.00			2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,540,956		7,540,956	0	7,540,956	30.00
31.00	03100	INTENSIVE CARE UNIT	2,056,696		2,056,696	0	2,056,696	31.00
43.00	04300	NURSERY	236,051		236,051	0	236,051	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,150,804		11,150,804	0	11,150,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	785,829		785,829	0	785,829	52.00
53.00	05300	ANESTHESIOLOGY	400,749		400,749	0	400,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,272,823		4,272,823	0	4,272,823	54.00
54.01	05402	MRI	727,562		727,562	0	727,562	54.01
57.00	05700	CT SCAN	1,051,132		1,051,132	0	1,051,132	57.00
60.00	06000	LABORATORY	6,928,569		6,928,569	0	6,928,569	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	259,324		259,324	0	259,324	63.00
65.00	06500	RESPIRATORY THERAPY	1,243,449	0	1,243,449	0	1,243,449	65.00
66.00	06600	PHYSICAL THERAPY	2,935,942	0	2,935,942	0	2,935,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,939	0	299,939	0	299,939	67.00
68.00	06800	SPEECH PATHOLOGY	104,381	0	104,381	0	104,381	68.00
69.00	06900	ELECTROCARDIOLOGY	512,285		512,285	0	512,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,527		115,527	0	115,527	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,705,684		1,705,684	0	1,705,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,923,731		2,923,731	0	2,923,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,685,143		3,685,143	0	3,685,143	73.00
76.00	03020	SONOGRAPHY	1,169,687		1,169,687	0	1,169,687	76.00
76.01	03040	AUDIOLOGY	366,793		366,793	0	366,793	76.01
76.02	03160	CARDIAC REHAB	192,215		192,215	0	192,215	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	292,713		292,713	0	292,713	88.00
90.00	09000	CLINIC	17,881,498		17,881,498	0	17,881,498	90.00
91.00	09100	EMERGENCY	3,381,634		3,381,634	9,131	3,390,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,651,597		1,651,597		1,651,597	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,261,137		1,261,137	0	1,261,137	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,402,694		1,402,694		1,402,694	116.00
200.00		Subtotal (see instructions)	76,536,544	0	76,536,544	9,131	76,545,675	200.00
201.00		Less Observation Beds	1,651,597		1,651,597		1,651,597	201.00
202.00		Total (see instructions)	74,884,947	0	74,884,947	9,131	74,894,078	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/23/2022 11:01 am

			Title XIX		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,022,147		8,022,147		30.00
31.00	03100	INTENSIVE CARE UNIT	2,460,182		2,460,182		31.00
43.00	04300	NURSERY	612,731		612,731		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,311,099	31,222,985	38,534,084	0.289375	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,003,523	106,882	1,110,405	0.707696	52.00
53.00	05300	ANESTHESIOLOGY	2,245,452	7,051,574	9,297,026	0.043105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,479,907	10,574,876	12,054,783	0.354450	54.00
54.01	05402	MRI	353,878	7,548,468	7,902,346	0.092069	54.01
57.00	05700	CT SCAN	2,250,567	14,515,496	16,766,063	0.062694	57.00
60.00	06000	LABORATORY	8,480,542	39,438,898	47,919,440	0.144588	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	208,581	161,083	369,664	0.701513	63.00
65.00	06500	RESPIRATORY THERAPY	2,972,024	1,057,660	4,029,684	0.308572	65.00
66.00	06600	PHYSICAL THERAPY	739,262	11,074,084	11,813,346	0.248528	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,929	1,279,375	1,410,304	0.212677	67.00
68.00	06800	SPEECH PATHOLOGY	19,829	279,596	299,425	0.348605	68.00
69.00	06900	ELECTROCARDIOLOGY	2,480,805	4,692,965	7,173,770	0.071411	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,916	387,928	389,844	0.296342	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,963,195	6,167,538	13,130,733	0.129900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,220,809	1,643,220	3,864,029	0.756653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,124,991	4,255,858	8,380,849	0.439710	73.00
76.00	03020	SONOGRAPHY	1,180,031	7,623,888	8,803,919	0.132860	76.00
76.01	03040	AUDIOLOGY	0	590,648	590,648	0.621001	76.01
76.02	03160	CARDIAC REHAB	4,884	913,233	918,117	0.209358	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	285,272	285,272	1.026084	88.00
90.00	09000	CLINIC	93,000	5,411,319	5,504,319	3.248630	90.00
91.00	09100	EMERGENCY	1,758,311	9,740,515	11,498,826	0.294085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	180,963	2,275,058	2,456,021	0.672469	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,859	1,026,414	1,032,273	1.221709	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,917,513	1,917,513		116.00
200.00		Subtotal (see instructions)	57,305,417	171,242,346	228,547,763		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	57,305,417	171,242,346	228,547,763		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289375			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707696			52.00
53.00	05300	ANESTHESIOLOGY	0.043105			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.354450			54.00
54.01	05402	MRI	0.092069			54.01
57.00	05700	CT SCAN	0.062694			57.00
60.00	06000	LABORATORY	0.144588			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.701513			63.00
65.00	06500	RESPIRATORY THERAPY	0.308572			65.00
66.00	06600	PHYSICAL THERAPY	0.248528			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212677			67.00
68.00	06800	SPEECH PATHOLOGY	0.348605			68.00
69.00	06900	ELECTROCARDIOLOGY	0.071411			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296342			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.129900			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.756653			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439710			73.00
76.00	03020	SONOGRAPHY	0.132860			76.00
76.01	03040	AUDIOLOGY	0.621001			76.01
76.02	03160	CARDIAC REHAB	0.209358			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.026084			88.00
90.00	09000	CLINIC	3.248630			90.00
91.00	09100	EMERGENCY	0.294879			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672469			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.221709			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
5/23/2022 11:01 am

			Title XIX			Hospital	PPS	
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,150,804	1,351,363	9,799,441	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	785,829	50,901	734,928	0	0	52.00
53.00	05300	ANESTHESIOLOGY	400,749	92,362	308,387	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,272,823	785,951	3,486,872	0	0	54.00
54.01	05402	MRI	727,562	97,364	630,198	0	0	54.01
57.00	05700	CT SCAN	1,051,132	184,436	866,696	0	0	57.00
60.00	06000	LABORATORY	6,928,569	297,874	6,630,695	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	259,324	8,968	250,356	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,243,449	77,148	1,166,301	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,935,942	201,887	2,734,055	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,939	8,968	290,971	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	104,381	4,701	99,680	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	512,285	22,235	490,050	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,527	17,696	97,831	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,705,684	157,190	1,548,494	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,923,731	67,981	2,855,750	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,685,143	144,127	3,541,016	0	0	73.00
76.00	03020	SONOGRAPHY	1,169,687	49,433	1,120,254	0	0	76.00
76.01	03040	AUDIOLOGY	366,793	8,971	357,822	0	0	76.01
76.02	03160	CARDIAC REHAB	192,215	23,802	168,413	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	292,713	6,839	285,874	0	0	88.00
90.00	09000	CLINIC	17,881,498	926,227	16,955,271	0	0	90.00
91.00	09100	EMERGENCY	3,381,634	282,993	3,098,641	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,651,597	163,791	1,487,806	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,261,137	29,182	1,231,955	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,402,694	74,245	1,328,449	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	66,702,841	5,136,635	61,566,206	0	0	200.00
201.00		Less Observation Beds	1,651,597	163,791	1,487,806	0	0	201.00
202.00		Total (line 200 minus line 201)	65,051,244	4,972,844	60,078,400	0	0	202.00

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

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,150,804	38,534,084	0.289375	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	785,829	1,110,405	0.707696	52.00
53.00	05300	ANESTHESIOLOGY	400,749	9,297,026	0.043105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,272,823	12,054,783	0.354450	54.00
54.01	05402	MRI	727,562	7,902,346	0.092069	54.01
57.00	05700	CT SCAN	1,051,132	16,766,063	0.062694	57.00
60.00	06000	LABORATORY	6,928,569	47,919,440	0.144588	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	259,324	369,664	0.701513	63.00
65.00	06500	RESPIRATORY THERAPY	1,243,449	4,029,684	0.308572	65.00
66.00	06600	PHYSICAL THERAPY	2,935,942	11,813,346	0.248528	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,939	1,410,304	0.212677	67.00
68.00	06800	SPEECH PATHOLOGY	104,381	299,425	0.348605	68.00
69.00	06900	ELECTROCARDIOLOGY	512,285	7,173,770	0.071411	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,527	389,844	0.296342	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,705,684	13,130,733	0.129900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,923,731	3,864,029	0.756653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,685,143	8,380,849	0.439710	73.00
76.00	03020	SONOGRAPHY	1,169,687	8,803,919	0.132860	76.00
76.01	03040	AUDIOLOGY	366,793	590,648	0.621001	76.01
76.02	03160	CARDIAC REHAB	192,215	918,117	0.209358	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	292,713	285,272	1.026084	88.00
90.00	09000	CLINIC	17,881,498	5,504,319	3.248630	90.00
91.00	09100	EMERGENCY	3,381,634	11,498,826	0.294085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,651,597	2,456,021	0.672469	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,261,137	1,032,273	1.221709	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	1,402,694	1,917,513	0.731517	116.00
200.00		Subtotal (sum of lines 50 thru 199)	66,702,841	217,452,703		200.00
201.00		Less Observation Beds	1,651,597	0		201.00
202.00		Total (line 200 minus line 201)	65,051,244	217,452,703		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN:14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part I Date/Time Prepared: 5/23/2022 11:01 am		
				Title XVIII	Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	747,845	555	747,290	5,735	130.30	30.00	
31.00	INTENSIVE CARE UNIT	189,865		189,865	776	244.67	31.00	
43.00	NURSERY	47,103		47,103	443	106.33	43.00	
200.00	Total (lines 30 through 199)	984,813		984,258	6,954		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,495	325,099					30.00
31.00	INTENSIVE CARE UNIT	329	80,496					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	2,824	405,595					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part II Date/Time Prepared: 5/23/2022 11:01 am	
				Title XVIII		Hospital	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,351,363	38,534,084	0.035069	4,248,065	148,975
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,901	1,110,405	0.045840	0	0
53.00	05300	ANESTHESIOLOGY	92,362	9,297,026	0.009935	1,009,784	10,032
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,951	12,054,783	0.065198	1,066,020	69,502
54.01	05402	MRI	97,364	7,902,346	0.012321	230,509	2,840
57.00	05700	CT SCAN	184,436	16,766,063	0.011001	1,268,997	13,960
60.00	06000	LABORATORY	297,874	47,919,440	0.006216	4,950,095	30,770
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,968	369,664	0.024260	145,145	3,521
65.00	06500	RESPIRATORY THERAPY	77,148	4,029,684	0.019145	1,893,007	36,242
66.00	06600	PHYSICAL THERAPY	201,887	11,813,346	0.017090	457,029	7,811
67.00	06700	OCCUPATIONAL THERAPY	8,968	1,410,304	0.006359	71,025	452
68.00	06800	SPEECH PATHOLOGY	4,701	299,425	0.015700	15,039	236
69.00	06900	ELECTROCARDIOLOGY	22,235	7,173,770	0.003099	1,587,044	4,918
70.00	07000	ELECTROENCEPHALOGRAPHY	17,696	389,844	0.045393	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,190	13,130,733	0.011971	2,879,245	34,467
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,981	3,864,029	0.017593	1,328,457	23,372
73.00	07300	DRUGS CHARGED TO PATIENTS	144,127	8,380,849	0.017197	3,216,676	55,317
76.00	03020	SONOGRAPHY	49,433	8,803,919	0.005615	574,581	3,226
76.01	03040	AUDIOLOGY	8,971	590,648	0.015188	0	0
76.02	03160	CARDIAC REHAB	23,802	918,117	0.025925	4,884	127
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,839	285,272	0.023974	0	0
90.00	09000	CLINIC	926,227	5,504,319	0.168273	92,658	15,592
91.00	09100	EMERGENCY	282,993	11,498,826	0.024611	1,075,057	26,458
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	163,791	2,456,021	0.066690	87,563	5,840
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	5,033,208	214,502,917		26,200,880	493,658

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 5/23/2022 11:01 am	
					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	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	5,735	0.00	2,495	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	776	0.00	329	31.00		
43.00	04300	NURSERY	0	0	443	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	6,954		2,824	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						
31.00	03100	INTENSIVE CARE UNIT	0	0						
43.00	04300	NURSERY	0	0						
200.00		Total (lines 30 through 199)	0	0						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 5/23/2022 11:01 am	
			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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	MRI	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Title XVIII		Hospital		PPS
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	38,534,084	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,110,405	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	9,297,026	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,054,783	0.000000
54.01	05402	MRI	0	0	0	7,902,346	0.000000
57.00	05700	CT SCAN	0	0	0	16,766,063	0.000000
60.00	06000	LABORATORY	0	0	0	47,919,440	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	369,664	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,029,684	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	11,813,346	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,410,304	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	299,425	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,173,770	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	389,844	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,130,733	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,864,029	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,380,849	0.000000
76.00	03020	SONOGRAPHY	0	0	0	8,803,919	0.000000
76.01	03040	AUDIOLOGY	0	0	0	590,648	0.000000
76.02	03160	CARDIAC REHAB	0	0	0	918,117	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	285,272	0.000000
90.00	09000	CLINIC	0	0	0	5,504,319	0.000000
91.00	09100	EMERGENCY	0	0	0	11,498,826	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,456,021	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	0	0	0	214,502,917	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/23/2022 11:01 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,248,065	0	9,694,384	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	37	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,009,784	0	1,958,835	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,066,020	0	4,111,453	0	54.00
54.01	05402	MRI	0.000000	230,509	0	2,084,046	0	54.01
57.00	05700	CT SCAN	0.000000	1,268,997	0	5,334,780	0	57.00
60.00	06000	LABORATORY	0.000000	4,950,095	0	4,874,880	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	145,145	0	83,789	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,893,007	0	379,587	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	457,029	0	35,058	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	71,025	0	533	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,039	0	879	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,587,044	0	1,459,436	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	65,106	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,879,245	0	1,857,279	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,328,457	0	279,782	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,216,676	0	1,676,146	0	73.00
76.00	03020	SONOGRAPHY	0.000000	574,581	0	2,384,235	0	76.00
76.01	03040	AUDIOLOGY	0.000000	0	0	66,863	0	76.01
76.02	03160	CARDIAC REHAB	0.000000	4,884	0	390,554	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	92,658	0	2,619,745	0	90.00
91.00	09100	EMERGENCY	0.000000	1,075,057	0	2,582,349	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	87,563	0	1,033,836	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		26,200,880	0	42,973,592	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part IV Date/Time Prepared: 5/23/2022 11:01 am
			Title XVIII		Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01	05402	MRI	0	0	54.01	
57.00	05700	CT SCAN	0	0	57.00	
60.00	06000	LABORATORY	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.00	03020	SONOGRAPHY	0	0	76.00	
76.01	03040	AUDIOLOGY	0	0	76.01	
76.02	03160	CARDIAC REHAB	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			95.00	
200.00		Total (lines 50 through 199)	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
5/23/2022 11:01 am

			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	0.289375	9,694,384	0	0	2,805,312	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707696	37	0	0	26	52.00
53.00	05300	ANESTHESIOLOGY	0.043105	1,958,835	0	0	84,436	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.354450	4,111,453	10	1,262	1,457,305	54.00
54.01	05402	MRI	0.092069	2,084,046	0	0	191,876	54.01
57.00	05700	CT SCAN	0.062694	5,334,780	54	7,074	334,459	57.00
60.00	06000	LABORATORY	0.144588	4,874,880	8,245	0	704,849	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.701513	83,789	0	0	58,779	63.00
65.00	06500	RESPIRATORY THERAPY	0.308572	379,587	0	0	117,130	65.00
66.00	06600	PHYSICAL THERAPY	0.248528	35,058	0	0	8,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212677	533	0	0	113	67.00
68.00	06800	SPEECH PATHOLOGY	0.348605	879	0	0	306	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071411	1,459,436	0	0	104,220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296342	65,106	0	0	19,294	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.129900	1,857,279	0	0	241,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.756653	279,782	0	0	211,698	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439710	1,676,146	193	25,319	737,018	73.00
76.00	03020	SONOGRAPHY	0.132860	2,384,235	15	2,014	316,769	76.00
76.01	03040	AUDIOLOGY	0.621001	66,863	0	0	41,522	76.01
76.02	03160	CARDIAC REHAB	0.209358	390,554	0	0	81,766	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	3.248630	2,619,745	200	26,211	8,510,582	90.00
91.00	09100	EMERGENCY	0.294085	2,582,349	0	0	759,430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672469	1,033,836	0	0	695,223	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.221709		0			95.00
200.00		Subtotal (see instructions)		42,973,592	8,717	61,880	17,482,087	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,973,592	8,717	61,880	17,482,087	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 5/23/2022 11:01 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4	447					54.00
54.01	05402	MRI	0	0					54.01
57.00	05700	CT SCAN	3	443					57.00
60.00	06000	LABORATORY	1,192	0					60.00
60.01	06001	BLOOD LABORATORY	0	0					60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85	11,133					73.00
76.00	03020	SONOGRAPHY	2	268					76.00
76.01	03040	AUDIOLOGY	0	0					76.01
76.02	03160	CARDIAC REHAB	0	0					76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC	650	85,150					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0					93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	1,936	97,441					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	1,936	97,441					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0143

Period:

Worksheet D

Component CCN:14-U143

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
5/23/2022 11:01 am

			Title XVIII	Swing Beds - SNF		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.289375	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707696	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.043105	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.354450	0	0	0	0	54.00
54.01	05402	MRI	0.092069	0	0	0	0	54.01
57.00	05700	CT SCAN	0.062694	0	0	0	0	57.00
60.00	06000	LABORATORY	0.144588	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.701513	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.308572	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.248528	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212677	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.348605	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071411	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296342	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.129900	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.756653	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439710	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0.132860	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0.621001	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0.209358	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	3.248630	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.294085	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672469	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.221709		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0143

Period:

Worksheet D

Component CCN:14-U143

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
5/23/2022 11:01 am

			Title XVIII		Swing Beds - SNF	PPS
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05402	MRI	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	SONOGRAPHY	0	0		76.00
76.01	03040	AUDIOLOGY	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part I Date/Time Prepared: 5/23/2022 11:01 am		
				Title XIX	Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	747,845	555	747,290	5,735	130.30	30.00	
31.00	INTENSIVE CARE UNIT	189,865		189,865	776	244.67	31.00	
43.00	NURSERY	47,103		47,103	443	106.33	43.00	
200.00	Total (lines 30 through 199)	984,813		984,258	6,954		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	566	73,750					30.00
31.00	INTENSIVE CARE UNIT	102	24,956					31.00
43.00	NURSERY	190	20,203					43.00
200.00	Total (lines 30 through 199)	858	118,909					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part II Date/Time Prepared: 5/23/2022 11:01 am
Title XIX				Hospital	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,351,363	38,534,084	0.035069	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	50,901	1,110,405	0.045840	0	0	52.00
53.00 05300 ANESTHESIOLOGY	92,362	9,297,026	0.009935	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	785,951	12,054,783	0.065198	0	0	54.00
54.01 05402 MRI	97,364	7,902,346	0.012321	0	0	54.01
57.00 05700 CT SCAN	184,436	16,766,063	0.011001	0	0	57.00
60.00 06000 LABORATORY	297,874	47,919,440	0.006216	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	8,968	369,664	0.024260	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	77,148	4,029,684	0.019145	0	0	65.00
66.00 06600 PHYSICAL THERAPY	201,887	11,813,346	0.017090	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	8,968	1,410,304	0.006359	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	4,701	299,425	0.015700	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	22,235	7,173,770	0.003099	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	17,696	389,844	0.045393	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157,190	13,130,733	0.011971	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	67,981	3,864,029	0.017593	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	144,127	8,380,849	0.017197	0	0	73.00
76.00 03020 SONOGRAPHY	49,433	8,803,919	0.005615	0	0	76.00
76.01 03040 AUDIOLOGY	8,971	590,648	0.015188	0	0	76.01
76.02 03160 CARDIAC REHAB	23,802	918,117	0.025925	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	6,839	285,272	0.023974	0	0	88.00
90.00 09000 CLINIC	926,227	5,504,319	0.168273	0	0	90.00
91.00 09100 EMERGENCY	282,993	11,498,826	0.024611	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	163,791	2,456,021	0.066690	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	5,033,208	214,502,917		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part III Date/Time Prepared: 5/23/2022 11:01 am	
				Title XIX		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	0	0	0	0	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0	0
200.00		Total (lines 30 through 199)	0	0	0	0	0	0
Cost Center Description				Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days
				4.00	5.00	6.00	7.00	8.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	5,735	0.00	566	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	776	0.00	102	31.00
43.00	04300	NURSERY	0	0	443	0.00	190	43.00
200.00		Total (lines 30 through 199)	0	0	6,954		858	200.00
Cost Center Description				Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost			
				9.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description			Title XIX		Hospital		PPS	
			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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	MRI	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 5/23/2022 11:01 am	
			Title XIX		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	38,534,084	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,110,405	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,297,026	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,054,783	0.000000	54.00
54.01	05402	MRI	0	0	0	7,902,346	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	16,766,063	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	47,919,440	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	369,664	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,029,684	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,813,346	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,410,304	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	299,425	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,173,770	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	389,844	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,130,733	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,864,029	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,380,849	0.000000	73.00
76.00	03020	SONOGRAPHY	0	0	0	8,803,919	0.000000	76.00
76.01	03040	AUDIOLOGY	0	0	0	590,648	0.000000	76.01
76.02	03160	CARDIAC REHAB	0	0	0	918,117	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	285,272	0.000000	88.00
90.00	09000	CLINIC	0	0	0	5,504,319	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,498,826	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,456,021	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	214,502,917		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/23/2022 11:01 am

				Title XIX		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05402	MRI	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0.000000	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0.000000	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0.000000	0	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/23/2022 11:01 am

				Title XIX		Hospital		PPS	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05402	MRI	0	0					54.01
57.00	05700	CT SCAN	0	0					57.00
60.00	06000	LABORATORY	0	0					60.00
60.01	06001	BLOOD LABORATORY	0	0					60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03020	SONOGRAPHY	0	0					76.00
76.01	03040	AUDIOLOGY	0	0					76.01
76.02	03160	CARDIAC REHAB	0	0					76.02
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0					93.00
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0	0					200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 5/23/2022 11:01 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,735	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)			4,478	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)			23	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			2,495	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			237.99	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			243.34	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			237.99	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			243.34	20.00
21.00	Total general inpatient routine service cost (see instructions)			7,540,956	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)			5,597	25.00
26.00	Total swing-bed cost (see instructions)			5,597	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			7,535,359	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)			7,535,359	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)			1,313.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,278,230	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)			3,278,230	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,056,696	776	2,650.38	329	871,975	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,948,251	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,098,456	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)					405,595	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					493,658	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					899,253	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,199,203	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)					1,257	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,313.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,651,597	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 5/23/2022 11:01 am		
				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	747,845	7,540,956	0.099171	1,651,597	163,791			90.00	
91.00	Nursing Program cost	0	7,540,956	0.000000	1,651,597	0			91.00	
92.00	Allied health cost	0	7,540,956	0.000000	1,651,597	0			92.00	
93.00	All other Medical Education	0	7,540,956	0.000000	1,651,597	0			93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 5/23/2022 11:01 am	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,735	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)			4,478	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)			23	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			566	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)			443	15.00
16.00	Nursery days (title V or XIX only)			190	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			237.99	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			243.34	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			237.99	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			243.34	20.00
21.00	Total general inpatient routine service cost (see instructions)			7,540,956	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)			5,597	25.00
26.00	Total swing-bed cost (see instructions)			5,597	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			7,535,359	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)			7,535,359	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)			1,313.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			743,679	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)			743,679	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	236,051	443	532.85	190	101,242	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,056,696	776	2,650.38	102	270,339	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,115,260	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)					118,909	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					118,909	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					996,351	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)					1,257	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,313.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,651,597	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 5/23/2022 11:01 am	
				Title XIX		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	747,845	7,540,956	0.099171	1,651,597	163,791	90.00		
91.00	Nursing Program cost	0	7,540,956	0.000000	1,651,597	0	91.00		
92.00	Allied health cost	0	7,540,956	0.000000	1,651,597	0	92.00		
93.00	All other Medical Education	0	7,540,956	0.000000	1,651,597	0	93.00		

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 5/23/2022 11:01 am
Title XVIII			Hospital		PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,035,065	30.00
31.00	03100	INTENSIVE CARE UNIT		1,414,700	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.289375	4,248,065	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707696	0	52.00
53.00	05300	ANESTHESIOLOGY	0.043105	1,009,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.354450	1,066,020	54.00
54.01	05402	MRI	0.092069	230,509	54.01
57.00	05700	CT SCAN	0.062694	1,268,997	57.00
60.00	06000	LABORATORY	0.144588	4,950,095	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.701513	145,145	63.00
65.00	06500	RESPIRATORY THERAPY	0.308572	1,893,007	65.00
66.00	06600	PHYSICAL THERAPY	0.248528	457,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212677	71,025	67.00
68.00	06800	SPEECH PATHOLOGY	0.348605	15,039	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071411	1,587,044	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296342	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.129900	2,879,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.756653	1,328,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439710	3,216,676	73.00
76.00	03020	SONOGRAPHY	0.132860	574,581	76.00
76.01	03040	AUDIOLOGY	0.621001	0	76.01
76.02	03160	CARDIAC REHAB	0.209358	4,884	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	3.248630	92,658	90.00
91.00	09100	EMERGENCY	0.294879	1,075,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672469	87,563	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,200,880	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)		26,200,880	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143 Component CCN: 14-U143	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 5/23/2022 11:01 am	
			Title XVIII	Swing Beds - SNF	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289375	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707696	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.043105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.354450	0	0	54.00
54.01	05402	MRI	0.092069	0	0	54.01
57.00	05700	CT SCAN	0.062694	0	0	57.00
60.00	06000	LABORATORY	0.144588	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.701513	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.308572	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.248528	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212677	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.348605	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071411	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296342	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.129900	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.756653	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439710	0	0	73.00
76.00	03020	SONOGRAPHY	0.132860	0	0	76.00
76.01	03040	AUDIOLOGY	0.621001	0	0	76.01
76.02	03160	CARDIAC REHAB	0.209358	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	3.248630	0	0	90.00
91.00	09100	EMERGENCY	0.294879	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672469	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 5/23/2022 11:01 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			5,687,602	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)			136,663	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			40.49	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			0.86	30.00
31.00	Percentage of Medicaid patient days (see instructions)			15.31	31.00
32.00	Sum of lines 30 and 31			16.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)			3.26	33.00
34.00	Disproportionate share adjustment (see instructions)			46,354	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A
Date/Time Prepared:
5/23/2022 11:01 am

		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000000000		0.000086928	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	720,634	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	720,634	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		720,634		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)		6,591,253		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		6,802,876		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			6,749,970	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			443,469	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			319,497	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			7,512,936	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			7,512,936	61.00
62.00	Deductibles billed to program beneficiaries			693,272	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			52,740	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			34,281	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			46,784	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6,853,945	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			-69	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-3,635	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-2,601	70.93
70.94	HRR adjustment amount (see instructions)			-137,563	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 5/23/2022 11:01 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		73,691	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,636,386	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		8,378,699	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-1,742,313	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		158,717	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.9995669212	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		-69	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9771	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-3,635	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 DSH PAYMENT PERCENTAGE

Provider CCN: 14-0143

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

Worksheet DSH

Date/Time Prepared:
5/23/2022 11:01 am

		Title XVIII		Hospital		PPS	
		Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	0.86	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	15.31	0.00			15.31	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	16.17	0.00			15.31	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	40.49	0.00			40.49	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	3.26	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	771	0			771	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	87	0			87	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	0	0			0	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	33	0			33	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	891	0			891	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	5,720	0			5,720	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	100	0			100	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	22	0			22	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	23	0			23	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	5,819	0			5,819	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	15.31	0.00			15.31	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet DSH Date/Time Prepared: 5/23/2022 11:01 am	
				Title XVIII		Hospital		PPS	
				Original .mcrx Values		Adjusted .mcax Values		Revised	
				Condition	Percentage	Condition	Percentage	Condition	
				1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE									
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False		28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	3.26		0.00	True		29.00	
30.00	Line 28 or 29 as applicable		3.26		0.00			30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00			31.00	
				Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
				1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE									
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False		32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False		33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True		34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False		35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural		36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet DSH Date/Time Prepared: 5/23/2022 11:01 am
		Title XVIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	2.70		29.00
30.00	Line 28 or 29 as applicable	2.70		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/23/2022 11:01 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,687,602	0		5,687,602	5,687,602
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	136,663	0		136,663	136,663
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0326	0.0326	0.0326	0.0326	
11.00	Disproportionate share adjustment (see instructions)	34.00	46,354	0	0	46,354	46,354
11.01	Uncompensated care payments	36.00	720,634	0	0	291,352	291,352
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,591,253	0	0	6,591,253	6,591,253
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,802,876	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,749,970	0	0	6,749,970	6,749,970

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/23/2022 11:01 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	443,469	0	0	443,469	443,469
17.00	Special add-on payments for new technologies	54.00	319,497	0	0	319,497	319,497
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	7,512,936	7,512,936
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	424,468	0	0	424,468	424,468
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	19,001	0	0	19,001	19,001
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.00000	0.00000	0.00000	0.00000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.00000	0.00000	0.00000	0.00000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	443,469	0	0	443,469	443,469
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2022 11:01 am	
			Title XVIII		Hospital		PPS	
			Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
			0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01		0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02		5,687,602		5,687,602	5,687,602	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03		0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04		0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02		0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03		0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04		136,663		136,663	136,663	2.03
3.00	Operating outlier reconciliation	2.01		0	0	0	0	3.00
4.00	Managed care simulated payments	3.00		0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00		0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00		0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01		0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00		0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00		0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01		0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00		0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01		0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00		0.0326	0.0326	0.0326		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00		46,354	0	46,354	46,354	11.00
11.01	Uncompensated care payments	36.00		720,634	0	720,634	720,634	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00		0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00		6,591,253	0	6,591,253	6,591,253	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00		6,802,876	0	6,802,876	6,802,876	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00		6,749,970	0	6,749,970	6,749,970	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00		443,469	0	443,469	443,469	16.00
17.00	Special add-on payments for new technologies	54.00		319,497	0	319,497	319,497	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00		0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00		0	0	0	0	18.00
19.00	SUBTOTAL				0	7,512,936	7,512,936	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2022 11:01 am	
			Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	424,468	0	424,468	424,468	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	19,001	0	19,001	19,001	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	443,469	0	443,469	443,469	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-2,601	0	-2,601	-2,601	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-69	0	-69	-69	30.01	
31.00	HRR adjustment (see instructions)	70.94	-137,563	0	-137,563	-137,563	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-3,635	0	-3,635	-3,635	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	73,691	73,691	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 5/23/2022 11:01 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		99,377	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,482,087	2.00
3.00	OPPS payments		7,615,664	3.00
4.00	Outlier payment (see instructions)		341,961	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.799	5.00
6.00	Line 2 times line 5		13,968,188	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		56.97	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)		99,377	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		70,597	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)		70,597	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)		70,597	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		28,780	20.00
21.00	Lesser of cost or charges (see instructions)		70,597	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)		7,957,625	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,590,858	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		6,437,364	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		6,437,364	30.00
31.00	Primary payer payments		1,189	31.00
32.00	Subtotal (line 30 minus line 31)		6,436,175	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)		158,847	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		103,251	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		125,991	36.00
37.00	Subtotal (see instructions)		6,539,426	37.00
38.00	MSP-LCC reconciliation amount from PS&R		7	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,539,419	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		6,550,230	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)		-10,811	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: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 5/23/2022 11:01 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
5/23/2022 11:01 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,039,717		6,551,566	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	07/12/2021	1,661,018	07/12/2021	1,336	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)		-1,661,018		-1,336	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,378,699		6,550,230	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,742,313		10,811	6.02
7.00	Total Medicare program liability (see instructions)		6,636,386		6,539,419	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-0143

Period:

Worksheet E-1

Component CCN:14-U143

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
5/23/2022 11:01 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN:14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 5/23/2022 11:01 am	
		Title XVIII	Hospital	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 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 (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 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
				Overrides	
				1.00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet E-2	
		Component CCN:14-U143		Date/Time Prepared: 5/23/2022 11:01 am	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		0	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0143

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

Worksheet G

Date/Time Prepared:
5/23/2022 11:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,504,682	0	0	0	1.00
2.00	Temporary investments	5,781,481	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,593,830	0	0	0	4.00
5.00	Other receivable	6,803,124	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,047,599	0	0	0	7.00
8.00	Prepaid expenses	1,543,942	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	36,274,658	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,841,557	0	0	0	12.00
13.00	Land improvements	3,242,104	0	0	0	13.00
14.00	Accumulated depreciation	-2,711,239	0	0	0	14.00
15.00	Buildings	77,513,776	0	0	0	15.00
16.00	Accumulated depreciation	-48,303,507	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	35,482,342	0	0	0	23.00
24.00	Accumulated depreciation	-30,302,184	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	257,850	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,020,699	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	31,726,574	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,705,709	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,432,283	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	107,727,640	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,957,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,421,316	0	0	0	38.00
39.00	Payroll taxes payable	918,616	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,769,813	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,401,381	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,468,814	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	17,582,286	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	5,195,153	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,777,439	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,246,253	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	55,481,387				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	55,481,387	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	107,727,640	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0143

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

Worksheet G-1

Date/Time Prepared:
5/23/2022 11:01 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		57,277,575		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,248,826				2.00
3.00	Total (sum of line 1 and line 2)		56,028,749		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	DISTRIBUTION	50,498		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)		50,498		0		10.00
11.00	Subtotal (line 3 plus line 10)		56,079,247		0		11.00
12.00	EQUITY TRANSFER	597,860		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)		597,860		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,481,387		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	DISTRIBUTION		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 TRANSFER		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: 14-0143

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,086,082		10,086,082	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,086,082		10,086,082	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,884,543		4,884,543	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,884,543		4,884,543	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,970,625		14,970,625	17.00
18.00	Ancillary services	44,428,751	163,994,284	208,423,035	18.00
19.00	Outpatient services	0	26,268,812	26,268,812	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	5,859	1,030,826	1,036,685	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,927,901	1,927,901	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	59,405,235	193,221,823	252,627,058	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		99,609,329		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)		99,609,329		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet G-3 Date/Time Prepared: 5/23/2022 11:01 am
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			252,627,058 1.00
2.00	Less contractual allowances and discounts on patients' accounts			172,689,407 2.00
3.00	Net patient revenues (line 1 minus line 2)			79,937,651 3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			99,609,329 4.00
5.00	Net income from service to patients (line 3 minus line 4)			-19,671,678 5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc			33,611 6.00
7.00	Income from investments			7,315,394 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			191,677 14.00
15.00	Revenue from rental of living quarters			56,201 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			156,551 17.00
18.00	Revenue from sale of medical records and abstracts			1,330 18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0 19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0 20.00
21.00	Rental of vending machines			0 21.00
22.00	Rental of hospital space			122,197 22.00
23.00	Governmental appropriations			0 23.00
24.00	QUALITY REVENUE			67,521 24.00
24.01	INSURANCE PROCEEDS			2,040,872 24.01
24.02	OTHER (SPECIFY)			0 24.02
24.03	OTHER REVENUE			440,026 24.03
24.04	PARATRANSIT			181,587 24.04
24.05	OTHER (SPECIFY)			0 24.05
24.06	OTHER (SPECIFY)			0 24.06
24.07	OTHER (SPECIFY)			0 24.07
24.50	COVID-19 PHE Funding			7,832,291 24.50
25.00	Total other income (sum of lines 6-24)			18,439,258 25.00
26.00	Total (line 5 plus line 25)			-1,232,420 26.00
27.00	OTHER EXPENSES (SPECIFY)			0 27.00
27.01	OTHER EXPENSES (SPECIFY)			0 27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES			16,406 27.02
27.03	MISCELLANEOUS			0 27.03
27.04	OTHER EXPENSES (SPECIFY)			0 27.04
27.05	OTHER EXPENSES (SPECIFY)			0 27.05
28.00	Total other expenses (sum of line 27 and subscripts)			16,406 28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1,248,826 29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

		Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	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
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	0	37,488	37,488	0
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0
8.00	DIETARY*	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	14,855	14,855	0
11.00	MEDICAL RECORDS*	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	24,081	24,081	0
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0
14.00	PHARMACY*	0	10,657	10,657	0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES				
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**		0	0	0
26.00	PHYSICIAN SERVICES**	0	55,000	55,000	0
27.00	NURSE PRACTITIONER**	0	0	0	0
28.00	REGISTERED NURSE**	416,475	0	416,475	0
29.00	LPN/LVN**	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	58,323	0	58,323	0
34.00	SPIRITUAL COUNSELING**	0	0	0	0
35.00	DIETARY COUNSELING**	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	21,504	0	21,504	0
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0
39.00	PATIENT TRANSPORTATION**	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0
67.00	ADVERTISING*	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	285,181	285,181	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0
100.00	TOTAL	496,302	427,262	923,564	0

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

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I	
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	37,488		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	14,855		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	24,081		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	10,657		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	55,000		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	416,475		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	58,323		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	21,504		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
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	285,181		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	923,564		100.00

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

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

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

Provider CCN: 14-0143

Period:

Worksheet 0-1

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

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

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

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

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

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

Provider CCN: 14-0143

Period:

Worksheet 0-2

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

				Hospice I		07/20/2022 11:01 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	52,075	52,075	0	52,075	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	394,324	0	394,324	0	394,324	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	55,221	0	55,221	0	55,221	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	20,360	0	20,360	0	20,360	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 *	469,905	52,075	521,980	0	521,980	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	52,075	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	394,324	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	55,221	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	20,360	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	521,980	100.00

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

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

Provider CCN: 14-0143

Period:
From 10/01/2020

Worksheet 0-3

Hospice CCN: 14-1595

To 09/30/2021

Date/Time Prepared:
5/23/2022 11:01 am

						Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL			
		1.00	2.00	3.00	4.00	5.00			
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00		
26.00	PHYSICIAN SERVICES	0	79	79	0	79	26.00		
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00		
28.00	REGISTERED NURSE	599	0	599	0	599	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	84	0	84	0	84	33.00		
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00		
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00		
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00		
37.00	HOSPICE AIDE & HOME MAKER SERVICES	31	0	31	0	31	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 *	714	79	793	0	793	100.00		

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	79	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	599	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	84	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	31	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	793	100.00

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

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

Provider CCN: 14-0143

Period:

Worksheet 0-4

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

				Hospice I		07/26/2022 11:01 am	
		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	2,846	2,846	0	2,846	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	21,552	0	21,552	0	21,552	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	3,018	0	3,018	0	3,018	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,113	0	1,113	0	1,113	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 *	25,683	2,846	28,529	0	28,529	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	2,846	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	21,552	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	3,018	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	1,113	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	28,529	100.00

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION		Provider CCN: 14-0143 Hospice CCN: 14-1595	Period: From 10/01/2020 To 09/30/2021	Worksheet 0-5 Date/Time Prepared: 5/23/2022 11:01 am	
Descriptions		HOSPICE DIRECT EXPENSES (see instructions)	Hospice I GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	9,892	9,892	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	131,903	131,903	3.00
4.00	ADMINISTRATIVE & GENERAL	37,488	296,537	334,025	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	16,942	16,942	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	14,855	0	14,855	10.00
11.00	MEDICAL RECORDS	0	23,856	23,856	11.00
12.00	STAFF TRANSPORTATION	24,081	0	24,081	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	10,657	0	10,657	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	521,980	0	521,980	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	793	0	793	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28,529	0	28,529	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	285,181	0	285,181	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	923,564	479,130	1,402,694	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
5/23/2022 11:01 am

				Hospice I			
Descriptions		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	9,892	9,892				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	131,903	0	0	131,903		3.00
4.00	ADMINISTRATIVE & GENERAL	334,025	9,892	0	0	343,917	4.00
5.00	PLANT OPERATION & MAINTENANCE	16,942	0	0	0	16,942	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	14,855	0	0	0	14,855	10.00
11.00	MEDICAL RECORDS	23,856	0	0	0	23,856	11.00
12.00	STAFF TRANSPORTATION	24,081	0	0	0	24,081	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	10,657	0	0	0	10,657	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	521,980			124,886	646,866	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	793	0	0	189	982	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28,529	0	0	6,828	35,357	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	285,181				285,181	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,402,694	9,892	0	131,903	1,402,694	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS				Provider CCN: 14-0143		Period: From 10/01/2020 To 09/30/2021		Worksheet 0-6 Part I Date/Time Prepared: 5/23/2022 11:01 am	
				Hospice CCN: 14-1595		Hospice I			
Descriptions				ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	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	343,917							4.00
5.00	PLANT OPERATION & MAINTENANCE	7,532	24,474						5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0				6.00
7.00	HOUSEKEEPING	0	0				0		7.00
8.00	DIETARY	0	0				0	0	8.00
9.00	NURSING ADMINISTRATION	0	0				0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,604	0				0		10.00
11.00	MEDICAL RECORDS	10,606	0				0		11.00
12.00	STAFF TRANSPORTATION	10,706	0				0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0				0		13.00
14.00	PHARMACY	4,738	0				0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0				0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0				0		17.00
LEVEL OF CARE									
50.00	HOSPICE CONTINUOUS HOME CARE	0							50.00
51.00	HOSPICE ROUTINE HOME CARE	287,575							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	437	0		0		0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	15,719	24,474		0		0	0	53.00
NONREIMBURSABLE COST CENTERS									
60.00	BEREAVEMENT PROGRAM	0	0				0		60.00
61.00	VOLUNTEER PROGRAM	0	0				0		61.00
62.00	FUNDRAISING	0	0				0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0				0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0				0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0				0		65.00
66.00	RESIDENTIAL CARE	0	0		0		0	0	66.00
67.00	ADVERTISING	0	0				0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0				0		68.00
69.00	THRIFT STORE	0	0				0		69.00
70.00	NURSING FACILITY ROOM & BOARD								70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0		0	0	99.00
100.00	TOTAL	343,917	24,474		0		0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
5/23/2022 11:01 am

Descriptions		Hospice I					
		NURSING ADMINISTRATIO N	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATIO N	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	21,459				10.00
11.00	MEDICAL RECORDS	0		34,462			11.00
12.00	STAFF TRANSPORTATION	0			34,787		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	20,318	32,629	34,787	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	31	50	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	1,110	1,783	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	21,459	34,462	34,787	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
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Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	15,395					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	15,395	0	0		1,037,570	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,500	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	78,443	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					285,181	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	15,395	0	0	0	1,402,694	100.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	974					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	496,311			3.00
4.00	ADMINISTRATIVE & GENERAL	974	0	0	-343,917	773,596	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	16,942	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	14,855	10.00
11.00	MEDICAL RECORDS	0	0	0	0	23,856	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	24,081	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	10,657	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			469,905	0	646,866	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	713	0	982	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	25,693	0	35,357	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				-285,181		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	9,892	0	131,903		343,917	100.00
101.00	UNIT COST MULTIPLIER	10.156057	0.000000	0.265767		0.444569	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
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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 ADMINISTRATIO N (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	974					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	974	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	24,474	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	25.127310	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,261					10.00
11.00	MEDICAL RECORDS		6,261				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	100	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,928	5,928	100	0	100	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9	9	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	324	324	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	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	21,459	34,462	34,787	0	15,395	100.00
101.00	UNIT COST MULTIPLIER	3.427408	5.504233	347.870000	0.000000	153.950000	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
5/23/2022 11:01 am

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

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

Provider CCN: 14-0143

Period:

Worksheet 0-7

Hospice CCN: 14-1595

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

Date/Time Prepared:
5/23/2022 11:01 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
1.00	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.248528	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.212677	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.348605	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.439710	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.144588	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.129900	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	SONOGRAPHY	76.00	0.132860	0	0	0	10.00
10.01	AUDIOLOGY	76.01	0.621001	0	0	0	10.01
10.02	CARDIAC REHAB	76.02	0.209358	0	0	0	10.02
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	
1.00	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
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	SONOGRAPHY	0	0	0	0	0	10.00
10.01	AUDIOLOGY	0	0	0	0	0	10.01
10.02	CARDIAC REHAB	0	0	0	0	0	10.02
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0143

Period:

Worksheet 0-8

Hospice CCN: 14-1595

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,037,570	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,928	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			175.03	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,275	652		9.00
10.00	Program cost (line 8 times line 9)	573,223	114,120		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			1,500	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			9	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			166.67	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	9	0		14.00
15.00	Program cost (line 13 times line 14)	1,500	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)			78,443	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			324	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			242.11	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	101	2		19.00
20.00	Program cost (line 18 times line 19)	24,453	484		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,117,513	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			6,261	22.00
23.00	Average cost per diem (line 21 divided by line 22)			178.49	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0143	Period: From 10/01/2020 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 5/23/2022 11:01 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		424,468	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		19,001	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		14.73	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		443,469	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: 14-0143

Period:

Worksheet M-1

Component CCN: 14-8623

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

		RHC I				
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	47,189	47,189
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	0	0	0	17,964	17,964
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	77,949	77,949
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	143,102	143,102
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	0	0	28,340	28,340
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	8,041	8,041
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	36,381	36,381
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	179,483	179,483
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	7,721	7,721
30.00	Administrative Costs	0	0	0	980	980
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	8,701	8,701
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	188,184	188,184

Health Financial Systems		ST. MARGARETS HEALTH - SPRING VALLEY		In Lieu of Form CMS-2552-10	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Provider CCN: 14-0143		Period:
			Component CCN: 14-8623		From 10/01/2020 To 09/30/2021
					Worksheet M-1 Date/Time Prepared: 5/23/2022 11:01 am
			Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I
			6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	47,189		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	17,964		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	77,949		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	143,102		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	28,340		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	8,041		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36,381		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	179,483		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	7,721		29.00
30.00	Administrative Costs	0	980		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,701		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	188,184		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-0143

Period:

Worksheet M-2

Component CCN:14-8623

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

		RHC I					
		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	0.25	756	4,200	1,050		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.17	400	2,100	357		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.42	1,156		1,407	1,407	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)	0.42	1,156			1,407	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)					179,483	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					179,483	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					8,701	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					104,529	15.00
16.00	Total overhead (sum of lines 14 and 15)					113,230	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					113,230	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					113,230	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					292,713	20.00

Health Financial Systems		ST. MARGARETS HEALTH - SPRING VALLEY		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0143	Period: From 10/01/2020	Worksheet M-3	
		Component CCN: 14-8623	To 09/30/2021	Date/Time Prepared: 5/23/2022 11:01 am	
		Title XVIII	RHC I		
				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)			292,713	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			28	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			292,685	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,407	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)			1,407	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			208.02	7.00
		Calculation of Limit (1)			
		Rate Period 1	Rate Period 2	Rate Period 3	
		(10/01/2020 through 12/31/2020)	(01/01/2021 through 03/31/2021)	(04/01/2021 through 09/30/2021)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	208.02	208.02	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	288	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	28,800	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	28,800		16.00
16.01	Total program charges (see instructions)(from contractor's records)		0		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		23,040		16.04
16.05	Total program cost (see instructions)	0	23,040		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		23,040		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		23,068		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)		23,068		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		23,040		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)		28		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: 14-0143

Period:

Worksheet M-4

Component CCN: 14-8623

From 10/01/2020
To 09/30/2021Date/Time Prepared:
5/23/2022 11:01 am

		Title XVIII		RHC I		
		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)	143,102	143,102	143,102	143,102	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000080	0.000040	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	11	6	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11	6	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	179,483	179,483	179,483	179,483	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	113,230	113,230	113,230	113,230	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000061	0.000033	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7	4	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	18	10	0	0	10.00
11.00	Total number of injections/infusions (from your records)	4	2	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	4.50	5.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	2	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	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)	18	10	0	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)		28			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)		28			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0143 Component CCN: 14-8623	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 5/23/2022 11:01 am	
		RHC I			
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		23,040	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)		23,040		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		28		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		23,068		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00