

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 11:01 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/28/2022	Time: 11:01 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION 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 IROQUOIS MEMORIAL HOSPITAL (14-0167) 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	Shawn Bransky	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Shawn Bransky		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronically)		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	-37,431	9,358	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		53,888		0	10.00
10.01 RURAL HEALTH CLINIC II	0		95,194		0	10.01
10.02 RURAL HEALTH CLINIC III	0		164,235		0	10.02
10.03 RURAL HEALTH CLINIC IV	0		-245,183		0	10.03
200.00 Total	0	-37,431	77,492	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:01 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 200 FAIRMAN AVENUE			PO Box:				1.00		
2.00	City: WATSEKA			State: IL		Zip Code: 60970		County:		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		IROQUOIS MEMORIAL HOSPITAL	140167	99914	1	07/01/1996	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		IROQUOIS MEMORIAL HOSPITAL	14U167	99914		12/31/2006	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		IROQUOIS RESIDENT HOME	146049	99914		08/18/2003	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		IROQUOIS HOME HEALTH	147586	99914		09/30/1994	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		IROQUOIS MEMORIAL HOSPICE	141616	99914		11/04/2004			
15.00	Hospital-Based Health Clinic - RHC		GILMAN CLINIC	143424	99914		09/04/1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		MILFORD CLINIC	143425	99914		10/09/1996	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		KENTLAND CLINIC	153979	99915		10/29/1996	N	O	N
15.03	Hospital-Based Health Clinic - RHC IV		MPS CLINIC	148551	99914		02/05/2016	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2020		09/30/2021	
21.00	Type of Control (see instructions)						2			
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			
22.02	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:01 am	
		1.00	2.00	3.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
		1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3	0	0	0	140	0
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	0
		Urban/Rural S				Date of Geogr	
		1.00				2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1				35.00	
		Beginning:				Ending:	
		1.00				2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2020				09/30/2021	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N				Y/N	
		1.00				2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y				Y	
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	
		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	
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	
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	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N				N	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N					
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:01 am	
			V 1.00	XVIII 2.00	XIX 3.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	
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
61.20	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
					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
62.01	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
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: 14-0167

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 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
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
				1.00	2.00	3.00	
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			609,669	0	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.			Y			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			Y		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:01 am	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				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:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 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: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 11:01 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for 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.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/10/2022	N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/28/2022 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?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT	BRILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500	CBRILL@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 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.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 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	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	35	12,775		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		61				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 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)	868	6	1,437			1.00
2.00	HMO and other (see instructions)	203	137				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	868	6	1,437			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)	868	6	1,437	0.00	177.68	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	620	0	10,540	0.00	25.80	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,336	0	4,927	0.00	8.04	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	87	0	87	0.00	11.91	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,436	0	3,648	0.00	4.79	26.00
26.01	RURAL HEALTH CLINIC II	902	0	2,369	0.00	3.78	26.01
26.02	RURAL HEALTH CLINIC III	2,604	0	4,424	0.00	5.56	26.02
26.03	RURAL HEALTH CLINIC IV	14,457	0	22,699	0.00	6.10	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	243.66	27.00
28.00	Observation Bed Days		4	393			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 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	246	2	467	1.00
2.00 HMO and other (see instructions)			54	45		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	246	2	467	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 11:01 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	14,309,236	0	14,309,236	506,809.00	28.23
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		15,642	0	15,642	104.00	150.40
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		213,624	0	213,624	1,080.00	197.80
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,418,918	0	2,418,918	42,066.00	57.50
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,254,338	0	1,254,338	53,668.00	23.37
10.00	Excluded area salaries (see instructions)		1,269,050	0	1,269,050	45,674.34	27.78
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		429,226	0	429,226	4,099.87	104.69
12.00	Contract labor: Top level management and other management and administrative services		489,165	0	489,165	2,080.00	235.18
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,011,983	0	2,011,983		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		550,846	0	550,846		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		1,443	0	1,443		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		18,357	0	18,357		
24.00	Wage-related costs (RHC/FQHC)		323,542	0	323,542		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 11:01 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	187,502	0	187,502	6,076.00	30.86	26.00
27.00	Administrative & General	5.00	1,423,490	0	1,423,490	62,617.00	22.73	27.00
28.00	Administrative & General under contract (see inst.)		350,863	0	350,863	1,711.63	204.99	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	339,784	0	339,784	16,540.00	20.54	30.00
31.00	Laundry & Linen Service	8.00	43,366	0	43,366	2,997.00	14.47	31.00
32.00	Housekeeping	9.00	337,392	0	337,392	24,730.00	13.64	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	375,502	-169,689	205,813	12,475.76	16.50	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	169,689	169,689	12,390.90	13.69	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	127,497	0	127,497	4,555.00	27.99	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	261,242	0	261,242	11,664.00	22.40	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/28/2022 11:01 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	12,027,557	0	12,027,557	465,374.63	25.84	1.00
2.00	Excluded area salaries (see instructions)	2,523,388	0	2,523,388	99,342.34	25.40	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,504,169	0	9,504,169	366,032.29	25.97	3.00
4.00	Subtotal other wages & related costs (see inst.)	918,391	0	918,391	6,179.87	148.61	4.00
5.00	Subtotal wage-related costs (see inst.)	2,013,426	0	2,013,426	0.00	21.18	5.00
6.00	Total (sum of lines 3 thru 5)	12,435,986	0	12,435,986	372,212.16	33.41	6.00
7.00	Total overhead cost (see instructions)	3,446,638	0	3,446,638	155,757.29	22.13	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2022 11:01 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		1,932,916	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		15,928	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		991,023	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		-33,697	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,906,170	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0167

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 2/28/2022 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	429,226	2,906,170	1.00
2.00	Hospital	429,226	2,906,170	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0167 Component CCN: 14-7586		Period: From 10/01/2020 To 09/30/2021 Worksheet S-4 Date/Time Prepared: 2/28/2022 11:01 am	
				Home Health Agency I		PPS	
				1.00			
0.00 County				IROQUOIS		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,744	0	76	1,820	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	208.00	8.00	39.00	274.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.02	0.00	0.02	4.00
5.00	Other Administrative Personnel			0.16	0.00	0.16	5.00
6.00	Direct Nursing Service			3.82	0.00	3.82	6.00
7.00	Nursing Supervisor			0.64	0.00	0.64	7.00
8.00	Physical Therapy Service			1.64	0.00	1.64	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.45	0.00	0.45	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.87	0.00	0.87	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					16580	20.00
20.01						19180	20.01
20.02						99914	20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,489	295	35	6	1,825	21.00
22.00	Skilled Nursing Visit Charges	255,556	50,402	6,049	1,037	313,044	22.00
23.00	Physical Therapy Visits	753	114	16	0	883	23.00
24.00	Physical Therapy Visit Charges	129,790	19,635	2,754	0	152,179	24.00
25.00	Occupational Therapy Visits	182	68	3	0	253	25.00
26.00	Occupational Therapy Visit Charges	31,082	11,673	518	0	43,273	26.00
27.00	Speech Pathology Visits	8	4	0	0	12	27.00
28.00	Speech Pathology Visit Charges	1,199	691	0	0	1,890	28.00
29.00	Medical Social Service Visits	9	3	0	0	12	29.00
30.00	Medical Social Service Visit Charges	1,716	644	0	0	2,360	30.00
31.00	Home Health Aide Visits	256	95	0	0	351	31.00
32.00	Home Health Aide Visit Charges	27,221	10,164	0	0	37,385	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,697	579	54	6	3,336	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	446,564	93,209	9,321	1,037	550,131	35.00
36.00	Total Number of Episodes (standard/non outlier)	256		24	1	281	36.00
37.00	Total Number of Outlier Episodes		28		0	28	37.00
38.00	Total Non-Routine Medical Supply Charges	11,368	12,546	224	89	24,227	38.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-3424		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/28/2022 11:01 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	508 E CRESENT		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GILMAN IL 60938		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		08:30 18:30 07:00 11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	07:00	17:00	08:30 18:30 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-3424

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

Date/Time Prepared:

2/28/2022 11:01 am

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-3425		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/28/2022 11:01 am	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	207 N AXTEL		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MILFORD IL 60983		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0		3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		08:30		17:00	
		17:00		07:00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:30	18:30	08:30
		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-3425

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

RHC II

Cost

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 15-3979		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/28/2022 11:01 am	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	303 N SEVENTH		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KENTLAND IN		47951	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:00		17:00	08:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	NEWTON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	18:30	07:00	17:00	08:30
		18:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 15-3979

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

RHC III

Cost

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

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0167 Component CCN: 14-8551		Period: From 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/28/2022 11:01 am	
		RHC IV		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	200 FAIRMAN AVE		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WATSEKA IL 60970		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
Facility hours of operations (1)					
11.00	CLINIC	07:00	17:00	08:30	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	IROQUOIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	18:30	07:00	17:00	08:30
		18:30		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0167

Period:

Worksheet S-8

Component CCN: 14-8551

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

RHC IV

Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA			Provider CCN: 14-0167 Hospice CCN: 14-1616	Period: From 10/01/2020 To 09/30/2021	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/28/2022 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	10,859	33	421	11,313	11.00
12.00	Hospice Inpatient Respite Care	69	0	3	72	12.00
13.00	Hospice General Inpatient Care	30	0	0	30	13.00
14.00	Total Hospice Days	10,958	33	424	11,415	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/28/2022 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)			0.464087 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	639,847		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	11,137,974		6.00
7.00	Medicaid cost (line 1 times line 6)	5,168,989		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)	4,529,142		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,529,142		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)	688,314	0	688,314 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	319,438	0	319,438 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	319,438	0	319,438 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,775,397		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	5,482		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	8,434		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,766,963		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	822,977		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,142,415		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,671,557		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0167

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

Worksheet A

Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	942,399	942,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	682,427	682,427	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	187,502	135,645	323,147	1,982,251	4.00
5.01	00570	ADMITTING	195,922	16,000	211,922	-68	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	71,264	19,377	90,641	-295	5.02
5.03	00550	DATA PROCESSING	277,193	672,496	949,689	-6,395	5.03
5.04	01160	COMMUNICATIONS	0	13,569	13,569	28,773	5.04
5.05	00590	BUSINESS OFFICE	356,416	76,963	433,379	-1,060	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	522,695	5,729,338	6,252,033	-3,067,249	5.06
7.00	00700	OPERATION OF PLANT	339,784	727,993	1,067,777	-14,143	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,366	5,030	48,396	0	8.00
9.00	00900	HOUSEKEEPING	337,392	49,716	387,108	0	9.00
10.00	01000	DIETARY	375,502	322,589	698,091	-315,818	10.00
11.00	01100	CAFETERIA	0	0	0	315,178	11.00
13.00	01300	NURSING ADMINISTRATION	127,497	3,053	130,550	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,273	92,273	-416	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	261,242	20,846	282,088	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,052,755	1,113,610	2,166,365	-7,584	30.00
44.00	04400	SKILLED NURSING FACILITY	1,254,338	905,417	2,159,755	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	771,261	516,047	1,287,308	-197,809	50.00
53.00	05300	ANESTHESIOLOGY	0	228,747	228,747	-3,196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	494,953	573,960	1,068,913	-34,821	54.00
57.00	05700	CT SCAN	180,818	126,285	307,103	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58,467	198,852	257,319	0	58.00
60.00	06000	LABORATORY	726,627	1,337,231	2,063,858	-52,948	60.00
65.00	06500	RESPIRATORY THERAPY	401,056	94,917	495,973	-43,806	65.00
66.00	06600	PHYSICAL THERAPY	763,857	49,046	812,903	-12	66.00
69.00	06900	ELECTROCARDIOLOGY	15,970	4,372	20,342	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	212,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	196,728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,249	1,377,954	1,815,203	-13,552	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	536,282	118,495	654,777	-68,887	88.00
88.01	08801	RURAL HEALTH CLINIC II	269,836	74,278	344,114	181,303	88.01
88.02	08802	RURAL HEALTH CLINIC III	700,958	201,729	902,687	-118,460	88.02
88.03	08803	RURAL HEALTH CLINIC IV	911,843	1,987,823	2,899,666	-262,851	88.03
90.00	09000	CLINIC	207,099	152,277	359,376	-41,091	90.00
91.00	09100	EMERGENCY	1,161,042	1,745,410	2,906,452	-33,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,872,724	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	544,056	117,047	661,103	-24,851	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	243,456	243,456	-225,551	113.00
116.00	11600	HOSPICE	684,628	294,894	979,522	-7,008	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,268,870	19,346,735	33,615,605	144	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	144	144	-144	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	40,366	5,655	46,021	0	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	14,309,236	19,352,534	33,661,770	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0167

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

Worksheet A

Date/Time Prepared:
2/28/2022 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	CAP REL COSTS-BLDG & FIXT	0	942,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	682,427	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-932	2,304,466	4.00
5.01	00570	ADMITTING	0	211,854	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-10	90,336	5.02
5.03	00550	DATA PROCESSING	0	943,294	5.03
5.04	01160	COMMUNICATIONS	-2,910	39,432	5.04
5.05	00590	BUSINESS OFFICE	0	432,319	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	-752,660	2,432,124	5.06
7.00	00700	OPERATION OF PLANT	-13,208	1,040,426	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,396	8.00
9.00	00900	HOUSEKEEPING	0	387,108	9.00
10.00	01000	DIETARY	-19,572	362,701	10.00
11.00	01100	CAFETERIA	-102,535	212,643	11.00
13.00	01300	NURSING ADMINISTRATION	0	130,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91,857	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,073	278,015	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-504,337	1,654,444	30.00
44.00	04400	SKILLED NURSING FACILITY	-824	2,158,931	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-233,453	856,046	50.00
53.00	05300	ANESTHESIOLOGY	-220,079	5,472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-29,922	1,004,170	54.00
57.00	05700	CT SCAN	0	307,103	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	257,319	58.00
60.00	06000	LABORATORY	-224,675	1,786,235	60.00
65.00	06500	RESPIRATORY THERAPY	-275	451,892	65.00
66.00	06600	PHYSICAL THERAPY	0	812,891	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	196,728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,243	1,799,408	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-1,891	583,999	88.00
88.01	08801	RURAL HEALTH CLINIC II	-125	525,292	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	784,227	88.02
88.03	08803	RURAL HEALTH CLINIC IV	-53,527	2,583,288	88.03
90.00	09000	CLINIC	-73,824	244,461	90.00
91.00	09100	EMERGENCY	-1,566,358	1,306,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	636,252	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-17,905	0	113.00
116.00	11600	HOSPICE	-1,026	971,488	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,826,364	29,789,385	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	46,021	194.01
194.02	07952	REFERENCE LAB	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,826,364	29,835,406	200.00

RECLASSIFICATIONS

Provider CCN: 14-0167

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 11:01 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	212,684		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	196,728		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	0		0	409,412		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,734		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	0		0	17,734		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	811,580		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	587,695		2.00
	0		0	1,399,275		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	130,819		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	94,732		2.00
	0		0	225,551		
	E - TELEPHONE					
1.00	COMMUNICATIONS	5.04	0	28,773		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	28,773		
	F - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,990,073		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	0		0	1,990,073		
	G - CAFETERIA					
1.00	CAFETERIA	11.00	169,689	145,489		1.00
	0		169,689	145,489		
	H - RHC SALARIES					
1.00	RURAL HEALTH CLINIC II	88.01	218,730	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		218,730	0		
	I - WOMEN'S HEALTH					
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	144		1.00
	TOTALS		0	144		
500.00	Grand Total: Increases		388,419	4,216,451		500.00

RECLASSIFICATIONS

Provider CCN: 14-0167

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 11:01 am

Decreases							500.00
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	318	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	7,582	0		2.00
3.00	OPERATING ROOM	50.00	0	197,212	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	3,196	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,806	0		5.00
6.00	LABORATORY	60.00	0	46,107	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	43,806	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	12	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	31,286	0		9.00
10.00	CLINIC	90.00	0	18,572	0		10.00
11.00	EMERGENCY	91.00	0	31,515	0		11.00
0			0	409,412			
B - DRUGS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,527	0		1.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	4,313	0		2.00
3.00	DIETARY	10.00	0	640	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2	0		4.00
5.00	OPERATING ROOM	50.00	0	597	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,586	0		6.00
7.00	LABORATORY	60.00	0	119	0		7.00
8.00	CLINIC	90.00	0	1,353	0		8.00
9.00	EMERGENCY	91.00	0	597	0		9.00
0			0	17,734			
C - DEPRECIATION							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,399,275	9		1.00
2.00		0.00	0	0	9		2.00
0			0	1,399,275			
D - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	225,551	11		1.00
2.00		0.00	0	0	11		2.00
0			0	225,551			
E - TELEPHONE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	295	0		1.00
2.00	ADMITTING	5.01	0	68	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	295	0		3.00
4.00	DATA PROCESSING	5.03	0	6,395	0		4.00
5.00	BUSINESS OFFICE	5.05	0	1,060	0		5.00
6.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	2,374	0		6.00
7.00	OPERATION OF PLANT	7.00	0	14,143	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	98	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,429	0		9.00
10.00	EMERGENCY	91.00	0	1,616	0		10.00
0			0	28,773			
F - EMPLOYEE BENEFITS							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,661,431	0		1.00
2.00	LABORATORY	60.00	0	6,722	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	32,728	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	0	37,427	0		4.00
5.00	RURAL HEALTH CLINIC III	88.02	0	73,381	0		5.00
6.00	RURAL HEALTH CLINIC IV	88.03	0	125,359	0		6.00
7.00	CLINIC	90.00	0	21,166	0		7.00
8.00	HOME HEALTH AGENCY	101.00	0	24,851	0		8.00
9.00	HOSPICE	116.00	0	7,008	0		9.00
0			0	1,990,073			
G - CAFETERIA							
1.00	DIETARY	10.00	169,689	145,489	0		1.00
0			169,689	145,489			
H - RHC SALARIES							
1.00	RURAL HEALTH CLINIC	88.00	36,159	0	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	45,079	0	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	137,492	0	0		3.00
0			218,730	0			
I - WOMEN'S HEALTH							
1.00	IROQUOIS WOMENS HEALTH	194.00	0	144	0		1.00
0	TOTALS		0	144			
500.00	Grand Total: Decreases		388,419	4,216,451			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 11:01 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	332,950	0	0	0	0	1.00	
2.00	Land Improvements	483,750	0	0	0	0	2.00	
3.00	Buildings and Fixtures	26,181,100	363,152	0	363,152	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	16,711,814	14,830	0	14,830	0	5.00	
6.00	Movable Equipment	0	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	43,709,614	377,982	0	377,982	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	43,709,614	377,982	0	377,982	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	332,950	0				1.00	
2.00	Land Improvements	483,750	0				2.00	
3.00	Buildings and Fixtures	26,544,252	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	16,726,644	0				5.00	
6.00	Movable Equipment	0	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	44,087,596	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	44,087,596	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 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	CAP REL COSTS-BLDG & FIXT	44,087,596	0	44,087,596	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	44,087,596	0	44,087,596	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	811,580	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	587,695	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,399,275	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	130,819	0	0	0	942,399	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	94,732	0	0	0	682,427	2.00
3.00	Total (sum of lines 1-2)	225,551	0	0	0	1,624,826	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0167

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-17,905	INTEREST EXPENSE	113.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,910	COMMUNICATIONS	5.04	0	7.00
8.00	Television and radio service (chapter 21)	A	-13,208	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	-2,768,739			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-360,000			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-102,535	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0167

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 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	
33.00	LOBBYING DUES	A	-8,545	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.00
33.01	LOBBYING DUES	A	-748	HOSPICE	116.00	0	33.01
34.00	MISCELLANEOUS NON-PATIENT REVENUE	B	-201,065	OTHER ADMINISTRATIVE & GENERAL	5.06	0	34.00
34.01	MISCELLANEOUS NON-PATIENT REVENUE	B	-932	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
34.02	MISCELLANEOUS NON-PATIENT REVENUE	B	-4,073	MEDICAL RECORDS & LIBRARY	16.00	0	34.02
34.03	MISCELLANEOUS NON-PATIENT REVENUE	B	-824	SKILLED NURSING FACILITY	44.00	0	34.03
34.04	MISCELLANEOUS NON-PATIENT REVENUE	B	-275	RESPIRATORY THERAPY	65.00	0	34.04
34.05	MISCELLANEOUS NON-PATIENT REVENUE	B	-19,572	DIETARY	10.00	0	34.05
34.06	MISCELLANEOUS NON-PATIENT REVENUE	B	-2,243	DRUGS CHARGED TO PATIENTS	73.00	0	34.06
34.07	MISCELLANEOUS NON-PATIENT REVENUE	B	-1,891	RURAL HEALTH CLINIC	88.00	0	34.07
34.08	MISCELLANEOUS NON-PATIENT REVENUE	B	-53,527	RURAL HEALTH CLINIC IV	88.03	0	34.08
34.09	MISCELLANEOUS NON-PATIENT REVENUE	B	-73,824	CLINIC	90.00	0	34.09
34.10	MISCELLANEOUS NON-PATIENT REVENUE	B	-598	EMERGENCY	91.00	0	34.10
34.11	NONALLOWABLE EXPENSES	A	-10	PURCHASING RECEIVING AND STORES	5.02	0	34.11
35.00	NONALLOWABLE EXPENSES	A	-192,537	OTHER ADMINISTRATIVE & GENERAL	5.06	0	35.00
35.01	NONALLOWABLE EXPENSES	A	-125	RURAL HEALTH CLINIC II	88.01	0	35.01
35.02	NONALLOWABLE EXPENSES	A	-278	HOSPICE	116.00	0	35.02
35.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,826,364				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0167

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 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	OTHER ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	60,000	420,000	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			60,000	420,000	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0167

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 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	-360,000	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-360,000			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0167

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

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 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	5.00	OTHER ADMINISTRATIVE & GENERAL	-9,487	-9,487	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	504,337	504,337	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	233,453	233,453	0	246,400	0	3.00
4.00	53.00	ANESTHESIOLOGY	220,079	220,079	0	239,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	43,517	25,000	18,517	271,900	104	5.00
6.00	60.00	LABORATORY	224,675	224,675	0	260,300	0	6.00
7.00	91.00	EMERGENCY	1,565,760	1,565,760	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,782,334	2,763,817	18,517		104	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	13,595	680	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			13,595	680	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	OTHER ADMINISTRATIVE & GENERAL	0	0	0	-9,487		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	504,337		2.00
3.00	50.00	OPERATING ROOM	0	0	0	233,453		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	220,079		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	13,595	4,922	29,922		5.00
6.00	60.00	LABORATORY	0	0	0	224,675		6.00
7.00	91.00	EMERGENCY	0	0	0	1,565,760		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	13,595	4,922	2,768,739		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	942,399	942,399			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	682,427		682,427		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,304,466	12,279	1,585	2,318,330	4.00
5.01	00570	ADMITTING	211,854	5,816	1,344	32,164	251,178 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	90,336	6,635	901	11,699	0 5.02
5.03	00550	DATA PROCESSING	943,294	16,989	43,330	45,506	0 5.03
5.04	01160	COMMUNICATIONS	39,432	1,224	0	0	0 5.04
5.05	00590	BUSINESS OFFICE	432,319	62,214	394	58,512	0 5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	2,432,124	50,368	5,964	85,810	0 5.06
7.00	00700	OPERATION OF PLANT	1,040,426	102,043	82,594	55,782	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,396	15,772	85	7,119	0 8.00
9.00	00900	HOUSEKEEPING	387,108	4,600	95	55,389	0 9.00
10.00	01000	DIETARY	362,701	22,984	1,593	33,788	0 10.00
11.00	01100	CAFETERIA	212,643	7,150	0	27,858	0 11.00
13.00	01300	NURSING ADMINISTRATION	130,550	7,308	0	20,931	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,857	10,347	4,695	0	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	278,015	9,247	56	42,888	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,654,444	63,837	39,233	172,829	10,890 30.00
44.00	04400	SKILLED NURSING FACILITY	2,158,931	67,316	19,109	205,914	12,039 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	856,046	112,011	166,712	126,616	31,154 50.00
53.00	05300	ANESTHESIOLOGY	5,472	756	558	0	501 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,004,170	31,489	64,981	81,255	21,071 54.00
57.00	05700	CT SCAN	307,103	6,284	88,380	29,685	27,083 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	257,319	0	281	9,598	4,860 58.00
60.00	06000	LABORATORY	1,786,235	24,208	17,136	119,289	38,821 60.00
65.00	06500	RESPIRATORY THERAPY	451,892	14,108	12,436	65,841	1,627 65.00
66.00	06600	PHYSICAL THERAPY	812,891	84,999	23,807	125,401	11,635 66.00
69.00	06900	ELECTROCARDIOLOGY	20,342	5,005	5,100	2,622	1,797 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	212,684	0	0	0	4,400 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	196,728	0	0	0	1,666 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,799,408	24,208	3,977	71,782	26,654 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	583,999	9,062	430	82,104	2,434 88.00
88.01	08801	RURAL HEALTH CLINIC II	525,292	19,299	14,935	80,207	1,330 88.01
88.02	08802	RURAL HEALTH CLINIC III	784,227	29,282	7,788	107,674	2,668 88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,583,288	16,590	12,480	127,124	14,532 88.03
90.00	09000	CLINIC	244,461	44,730	2,936	33,999	3,029 90.00
91.00	09100	EMERGENCY	1,306,366	31,771	24,474	190,606	22,391 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
101.00	10100	HOME HEALTH AGENCY	636,252	16,157	14,190	89,317	3,308 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	971,488	0	14,451	112,394	7,288 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,789,385	936,088	676,030	2,311,703	251,178 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,311	0	0	0 190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	46,021	0	4,114	6,627	0 194.01
194.02	07952	REFERENCE LAB	0	0	2,283	0	0 194.02
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	29,835,406	942,399	682,427	2,318,330	251,178 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description			PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	109,571					5.02
5.03	00550	DATA PROCESSING	4,250	1,053,369				5.03
5.04	01160	COMMUNICATIONS	1,546	0	42,202			5.04
5.05	00590	BUSINESS OFFICE	6,013	32,581	1,223	593,256		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	35,799	2,569	0	2,612,634	5.06
7.00	00700	OPERATION OF PLANT	7,732	31,723	1,468	0	1,321,768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,339	4,650	122	0	87,483	8.00
9.00	00900	HOUSEKEEPING	7,371	50,017	122	0	504,702	9.00
10.00	01000	DIETARY	941	30,958	1,101	0	454,066	10.00
11.00	01100	CAFETERIA	7,319	25,615	0	0	280,585	11.00
13.00	01300	NURSING ADMINISTRATION	4,465	19,222	1,346	0	183,822	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,681	0	0	0	110,580	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,766	33,655	4,281	0	370,908	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,667	104,061	8,441	25,724	2,085,126	30.00
44.00	04400	SKILLED NURSING FACILITY	14,141	116,526	1,468	28,438	2,623,882	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,920	47,615	4,526	73,591	1,423,191	50.00
53.00	05300	ANESTHESIOLOGY	166	0	0	1,183	8,636	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,330	49,367	2,691	49,772	1,306,126	54.00
57.00	05700	CT SCAN	0	7,365	0	63,974	529,874	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,866	0	11,480	288,404	58.00
60.00	06000	LABORATORY	11,664	56,446	1,957	91,638	2,147,394	60.00
65.00	06500	RESPIRATORY THERAPY	367	33,117	1,223	3,844	584,455	65.00
66.00	06600	PHYSICAL THERAPY	276	36,487	122	27,483	1,123,101	66.00
69.00	06900	ELECTROCARDIOLOGY	40	4,471	489	4,245	44,111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,522	0	0	10,394	231,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,268	0	0	3,934	206,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	474	25,337	979	62,962	2,015,781	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	107	19,947	0	5,750	703,833	88.00
88.01	08801	RURAL HEALTH CLINIC II	89	16,710	0	3,141	661,003	88.01
88.02	08802	RURAL HEALTH CLINIC III	201	29,657	0	6,302	967,799	88.02
88.03	08803	RURAL HEALTH CLINIC IV	158	33,084	3,058	34,326	2,824,640	88.03
90.00	09000	CLINIC	482	24,748	2,080	7,154	363,619	90.00
91.00	09100	EMERGENCY	2,210	63,513	2,324	52,891	1,696,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	512	27,772	0	7,814	795,322	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,486	59,335	0	17,216	1,183,658	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,503	1,024,644	41,590	593,256	29,740,645	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	245	0	6,556	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	68	28,404	245	0	85,479	194.01
194.02	07952	REFERENCE LAB	0	321	122	0	2,726	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,571	1,053,369	42,202	593,256	29,835,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description			OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	2,612,634					5.06
7.00	00700	OPERATION OF PLANT	126,853	1,448,621				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,396	33,362	129,241			8.00
9.00	00900	HOUSEKEEPING	48,437	9,729	0	562,868		9.00
10.00	01000	DIETARY	43,578	48,618	0	19,470	565,732	10.00
11.00	01100	CAFETERIA	26,928	15,125	0	6,057	0	11.00
13.00	01300	NURSING ADMINISTRATION	17,642	15,459	0	6,191	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,613	21,888	0	8,765	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,597	19,561	0	7,833	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	200,114	135,034	24,451	54,077	71,364	30.00
44.00	04400	SKILLED NURSING FACILITY	251,819	142,393	46,311	57,024	397,696	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	136,586	236,935	9,099	94,884	513	50.00
53.00	05300	ANESTHESIOLOGY	829	1,600	0	641	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,352	66,608	9,795	26,674	0	54.00
57.00	05700	CT SCAN	50,853	13,293	0	5,323	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,679	0	0	0	0	58.00
60.00	06000	LABORATORY	206,090	51,207	85	20,507	0	60.00
65.00	06500	RESPIRATORY THERAPY	56,091	29,843	0	11,951	0	65.00
66.00	06600	PHYSICAL THERAPY	107,786	179,798	14,725	72,003	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,233	10,587	0	4,240	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,170	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,827	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,459	51,207	0	20,507	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	67,548	19,168	0	7,676	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	63,438	40,823	0	16,348	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	92,882	61,940	0	24,805	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	271,094	35,093	0	14,054	0	88.03
90.00	09000	CLINIC	34,897	94,618	1,062	37,891	1,038	90.00
91.00	09100	EMERGENCY	162,821	67,204	23,713	26,913	6,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	76,329	34,177	0	13,687	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	113,598	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,603,539	1,435,270	129,241	557,521	477,069	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	629	13,351	0	5,347	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	8,204	0	0	0	88,663	194.01
194.02	07952	REFERENCE LAB	262	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,612,634	1,448,621	129,241	562,868	565,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	328,695					11.00
13.00	01300	NURSING ADMINISTRATION	4,870	227,984				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	151,846			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,609	0	7,648	456,156		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,391	71,939	15,671	19,780	2,718,947	30.00
44.00	04400	SKILLED NURSING FACILITY	63,303	0	39,104	21,866	3,643,398	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,913	38,710	13,606	56,584	2,032,021	50.00
53.00	05300	ANESTHESIOLOGY	2,435	0	459	910	15,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,913	0	3,677	38,270	1,598,415	54.00
57.00	05700	CT SCAN	7,304	0	0	49,190	655,837	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,435	0	0	8,827	327,345	58.00
60.00	06000	LABORATORY	38,956	0	32,252	70,459	2,566,950	60.00
65.00	06500	RESPIRATORY THERAPY	14,609	27,800	1,015	2,956	728,720	65.00
66.00	06600	PHYSICAL THERAPY	26,783	0	763	21,132	1,546,091	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	112	3,264	66,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,739	7,992	270,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,801	3,025	241,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,609	0	1,310	48,412	2,345,285	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	295	4,421	802,941	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	246	2,415	784,273	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	555	4,845	1,152,826	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	437	26,393	3,171,711	88.03
90.00	09000	CLINIC	9,739	16,830	1,333	5,501	566,528	90.00
91.00	09100	EMERGENCY	41,391	72,705	6,110	40,668	2,144,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	1,416	6,008	926,939	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	4,108	13,238	1,314,602	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	326,260	227,984	151,657	456,156	29,621,565	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	25,883	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	2,435	0	189	0	184,970	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	2,988	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	328,695	227,984	151,846	456,156	29,835,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	DATA PROCESSING			5.03
5.04	01160	COMMUNICATIONS			5.04
5.05	00590	BUSINESS OFFICE			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,718,947	30.00
44.00	04400	SKILLED NURSING FACILITY	0	3,643,398	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,032,021	50.00
53.00	05300	ANESTHESIOLOGY	0	15,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,598,415	54.00
57.00	05700	CT SCAN	0	655,837	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	327,345	58.00
60.00	06000	LABORATORY	0	2,566,950	60.00
65.00	06500	RESPIRATORY THERAPY	0	728,720	65.00
66.00	06600	PHYSICAL THERAPY	0	1,546,091	66.00
69.00	06900	ELECTROCARDIOLOGY	0	66,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	270,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	241,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,345,285	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	802,941	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	784,273	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,152,826	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,171,711	88.03
90.00	09000	CLINIC	0	566,528	90.00
91.00	09100	EMERGENCY	0	2,144,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	926,939	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	1,314,602	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	29,621,565	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,883	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	184,970	194.01
194.02	07952	REFERENCE LAB	0	2,988	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	29,835,406	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134	12,279	1,585	13,998	4.00
5.01	00570	ADMITTING	771	5,816	1,344	7,931	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	6,635	901	7,536	5.02
5.03	00550	DATA PROCESSING	28,628	16,989	43,330	88,947	5.03
5.04	01160	COMMUNICATIONS	0	1,224	0	1,224	5.04
5.05	00590	BUSINESS OFFICE	1,428	62,214	394	64,036	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	63,343	50,368	5,964	119,675	5.06
7.00	00700	OPERATION OF PLANT	5,334	102,043	82,594	189,971	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,772	85	15,857	8.00
9.00	00900	HOUSEKEEPING	0	4,600	95	4,695	9.00
10.00	01000	DIETARY	10,281	22,984	1,593	34,858	10.00
11.00	01100	CAFETERIA	0	7,150	0	7,150	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,308	0	7,308	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,347	4,695	15,042	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,247	56	9,303	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,888	63,837	39,233	108,958	30.00
44.00	04400	SKILLED NURSING FACILITY	0	67,316	19,109	86,425	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,380	112,011	166,712	293,103	50.00
53.00	05300	ANESTHESIOLOGY	0	756	558	1,314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,738	31,489	64,981	119,208	54.00
57.00	05700	CT SCAN	0	6,284	88,380	94,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	281	281	58.00
60.00	06000	LABORATORY	44,648	24,208	17,136	85,992	60.00
65.00	06500	RESPIRATORY THERAPY	4,833	14,108	12,436	31,377	65.00
66.00	06600	PHYSICAL THERAPY	1,080	84,999	23,807	109,886	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,005	5,100	10,105	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,280	24,208	3,977	32,465	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,817	9,062	430	21,309	88.00
88.01	08801	RURAL HEALTH CLINIC II	754	19,299	14,935	34,988	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,617	29,282	7,788	41,687	88.02
88.03	08803	RURAL HEALTH CLINIC IV	128	16,590	12,480	29,198	88.03
90.00	09000	CLINIC	0	44,730	2,936	47,666	90.00
91.00	09100	EMERGENCY	5,400	31,771	24,474	61,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	16,157	14,190	30,347	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	47,231	0	14,451	61,682	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	277,713	936,088	676,030	1,889,831	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,311	0	6,311	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	0	4,114	4,114	194.01
194.02	07952	REFERENCE LAB	0	0	2,283	2,283	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	277,713	942,399	682,427	1,902,539	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMITTING	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	8,125					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	7,607				5.02
5.03	00550	DATA PROCESSING	0	295	89,517			5.03
5.04	01160	COMMUNICATIONS	0	107	0	1,331		5.04
5.05	00590	BUSINESS OFFICE	0	417	2,769	39	67,614	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	0	3,042	81	0	5.06
7.00	00700	OPERATION OF PLANT	0	537	2,696	46	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	787	395	4	0	8.00
9.00	00900	HOUSEKEEPING	0	512	4,251	4	0	9.00
10.00	01000	DIETARY	0	65	2,631	35	0	10.00
11.00	01100	CAFETERIA	0	508	2,177	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	310	1,634	42	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	256	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	192	2,860	135	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	351	393	8,843	265	2,931	30.00
44.00	04400	SKILLED NURSING FACILITY	389	983	9,904	46	3,240	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,005	342	4,046	143	8,384	50.00
53.00	05300	ANESTHESIOLOGY	16	12	0	0	135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	680	92	4,195	85	5,671	54.00
57.00	05700	CT SCAN	874	0	626	0	7,289	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	157	0	413	0	1,308	58.00
60.00	06000	LABORATORY	1,270	810	4,797	62	10,464	60.00
65.00	06500	RESPIRATORY THERAPY	53	25	2,814	39	438	65.00
66.00	06600	PHYSICAL THERAPY	376	19	3,101	4	3,131	66.00
69.00	06900	ELECTROCARDIOLOGY	58	3	380	15	484	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	142	245	0	0	1,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54	296	0	0	448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	860	33	2,153	31	7,173	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	79	7	1,695	0	655	88.00
88.01	08801	RURAL HEALTH CLINIC II	43	6	1,420	0	358	88.01
88.02	08802	RURAL HEALTH CLINIC III	86	14	2,520	0	718	88.02
88.03	08803	RURAL HEALTH CLINIC IV	469	11	2,812	96	3,911	88.03
90.00	09000	CLINIC	98	33	2,103	66	815	90.00
91.00	09100	EMERGENCY	723	153	5,397	73	6,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	107	36	2,360	0	890	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	235	103	5,042	0	1,961	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,125	7,602	87,076	1,311	67,614	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	5	2,414	8	0	194.01
194.02	07952	REFERENCE LAB	0	0	27	4	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,125	7,607	89,517	1,331	67,614	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
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To 09/30/2021Worksheet B
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Cost Center Description			OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	123,316					5.06
7.00	00700	OPERATION OF PLANT	5,988	199,575				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	396	4,596	22,078			8.00
9.00	00900	HOUSEKEEPING	2,286	1,340	0	13,422		9.00
10.00	01000	DIETARY	2,057	6,698	0	464	47,012	10.00
11.00	01100	CAFETERIA	1,271	2,084	0	144	0	11.00
13.00	01300	NURSING ADMINISTRATION	833	2,130	0	148	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	501	3,015	0	209	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,680	2,695	0	187	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,446	18,603	4,177	1,289	5,930	30.00
44.00	04400	SKILLED NURSING FACILITY	11,886	19,617	7,912	1,360	33,048	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,447	32,644	1,554	2,264	43	50.00
53.00	05300	ANESTHESIOLOGY	39	220	0	15	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,917	9,177	1,673	636	0	54.00
57.00	05700	CT SCAN	2,400	1,831	0	127	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,306	0	0	0	0	58.00
60.00	06000	LABORATORY	9,728	7,055	15	489	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,648	4,111	0	285	0	65.00
66.00	06600	PHYSICAL THERAPY	5,088	24,771	2,515	1,717	0	66.00
69.00	06900	ELECTROCARDIOLOGY	200	1,459	0	101	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,046	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	936	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,131	7,055	0	489	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,188	2,641	0	183	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,994	5,624	0	390	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,384	8,533	0	591	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	12,794	4,835	0	335	0	88.03
90.00	09000	CLINIC	1,647	13,035	181	904	86	90.00
91.00	09100	EMERGENCY	7,685	9,259	4,051	642	537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	3,603	4,708	0	326	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	5,362	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,887	197,736	22,078	13,295	39,644	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30	1,839	0	127	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	387	0	0	0	7,368	194.01
194.02	07952	REFERENCE LAB	12	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	123,316	199,575	22,078	13,422	47,012	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	13,502					11.00
13.00	01300	NURSING ADMINISTRATION	200	12,731				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	19,023			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	600	0	958	18,869		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,700	4,017	1,963	819	170,728	30.00
44.00	04400	SKILLED NURSING FACILITY	2,602	0	4,900	906	184,467	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	900	2,162	1,704	2,344	357,849	50.00
53.00	05300	ANESTHESIOLOGY	100	0	57	38	1,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	900	0	461	1,585	150,770	54.00
57.00	05700	CT SCAN	300	0	0	2,037	110,327	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	100	0	0	366	3,989	58.00
60.00	06000	LABORATORY	1,600	0	4,040	2,895	129,937	60.00
65.00	06500	RESPIRATORY THERAPY	600	1,552	127	122	44,588	65.00
66.00	06600	PHYSICAL THERAPY	1,100	0	96	875	153,436	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14	135	12,970	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,220	331	4,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,478	125	3,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	600	0	164	2,005	62,592	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	37	183	30,473	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	31	100	46,438	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	70	201	59,454	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	55	1,093	56,376	88.03
90.00	09000	CLINIC	400	940	167	228	68,574	90.00
91.00	09100	EMERGENCY	1,700	4,060	765	1,684	105,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	177	249	43,342	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	515	548	76,126	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,402	12,731	18,999	18,869	1,877,438	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,315	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	100	0	24	0	14,460	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	2,326	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,502	12,731	19,023	18,869	1,902,539	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	DATA PROCESSING			5.03
5.04	01160	COMMUNICATIONS			5.04
5.05	00590	BUSINESS OFFICE			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	170,728	30.00
44.00	04400	SKILLED NURSING FACILITY	0	184,467	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	357,849	50.00
53.00	05300	ANESTHESIOLOGY	0	1,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,770	54.00
57.00	05700	CT SCAN	0	110,327	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,989	58.00
60.00	06000	LABORATORY	0	129,937	60.00
65.00	06500	RESPIRATORY THERAPY	0	44,588	65.00
66.00	06600	PHYSICAL THERAPY	0	153,436	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,970	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,592	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	30,473	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	46,438	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	59,454	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	56,376	88.03
90.00	09000	CLINIC	0	68,574	90.00
91.00	09100	EMERGENCY	0	105,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	43,342	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	76,126	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,877,438	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,315	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	14,460	194.01
194.02	07952	REFERENCE LAB	0	2,326	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,902,539	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	137,071					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,354,505				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,786	3,146	14,121,734			4.00
5.01	00570	ADMITTING	846	2,667	195,922	63,827,678		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	965	1,789	71,264	0	5,050,810	5.02
5.03	00550	DATA PROCESSING	2,471	86,003	277,193	0	195,922	5.03
5.04	01160	COMMUNICATIONS	178	0	0	0	71,264	5.04
5.05	00590	BUSINESS OFFICE	9,049	783	356,416	0	277,193	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	7,326	11,838	522,695	0	0	5.06
7.00	00700	OPERATION OF PLANT	14,842	163,936	339,784	0	356,416	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	169	43,366	0	522,695	8.00
9.00	00900	HOUSEKEEPING	669	189	337,392	0	339,784	9.00
10.00	01000	DIETARY	3,343	3,162	205,813	0	43,366	10.00
11.00	01100	CAFETERIA	1,040	0	169,689	0	337,392	11.00
13.00	01300	NURSING ADMINISTRATION	1,063	0	127,497	0	205,813	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	9,318	0	0	169,689	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	112	261,242	0	127,497	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,285	77,871	1,052,755	2,767,560	261,242	30.00
44.00	04400	SKILLED NURSING FACILITY	9,791	37,928	1,254,338	3,059,449	651,870	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,292	330,898	771,261	7,917,231	226,809	50.00
53.00	05300	ANESTHESIOLOGY	110	1,108	0	127,273	7,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,580	128,976	494,953	5,354,703	61,291	54.00
57.00	05700	CT SCAN	914	175,420	180,818	6,882,668	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	557	58,467	1,235,065	0	58.00
60.00	06000	LABORATORY	3,521	34,012	726,627	9,861,294	537,644	60.00
65.00	06500	RESPIRATORY THERAPY	2,052	24,683	401,056	413,553	16,919	65.00
66.00	06600	PHYSICAL THERAPY	12,363	47,253	763,857	2,956,769	12,716	66.00
69.00	06900	ELECTROCARDIOLOGY	728	10,122	15,970	456,715	1,860	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,118,253	162,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	423,256	196,728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,521	7,893	437,249	6,773,696	21,837	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,318	854	500,123	618,651	4,910	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,807	29,643	488,566	337,874	4,105	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,259	15,457	655,879	677,951	9,250	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,413	24,770	774,351	3,692,910	7,282	88.03
90.00	09000	CLINIC	6,506	5,827	207,099	769,704	22,216	90.00
91.00	09100	EMERGENCY	4,621	48,577	1,161,042	5,690,249	101,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,350	28,165	544,056	840,659	23,602	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	28,682	684,628	1,852,195	68,478	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,153	1,341,808	14,081,368	63,827,678	5,047,656	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	8,165	40,366	0	3,154	194.01
194.02	07952	REFERENCE LAB	0	4,532	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	942,399	682,427	2,318,330	251,178	109,571	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.875262	0.503820	0.164168	0.003935	0.021694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,998	8,125	7,607	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000991	0.000127	0.001506	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		DATA PROCESSING (TIME SPENT)	COMMUNICATIONS (# OF PHONES)	BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING	586,698				5.03
5.04	01160	COMMUNICATIONS	0	345			5.04
5.05	00590	BUSINESS OFFICE	18,147	10	63,827,678		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	19,939	21	0	-2,612,634	27,222,772
7.00	00700	OPERATION OF PLANT	17,669	12	0	0	1,321,768
8.00	00800	LAUNDRY & LINEN SERVICE	2,590	1	0	0	87,483
9.00	00900	HOUSEKEEPING	27,858	1	0	0	504,702
10.00	01000	DIETARY	17,243	9	0	0	454,066
11.00	01100	CAFETERIA	14,267	0	0	0	280,585
13.00	01300	NURSING ADMINISTRATION	10,706	11	0	0	183,822
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	110,580
16.00	01600	MEDICAL RECORDS & LIBRARY	18,745	35	0	0	370,908
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,959	69	2,767,560	0	2,085,126
44.00	04400	SKILLED NURSING FACILITY	64,903	12	3,059,449	0	2,623,882
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,520	37	7,917,231	0	1,423,191
53.00	05300	ANESTHESIOLOGY	0	0	127,273	0	8,636
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,496	22	5,354,703	0	1,306,126
57.00	05700	CT SCAN	4,102	0	6,882,668	0	529,874
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,710	0	1,235,065	0	288,404
60.00	06000	LABORATORY	31,439	16	9,861,294	0	2,147,394
65.00	06500	RESPIRATORY THERAPY	18,445	10	413,553	0	584,455
66.00	06600	PHYSICAL THERAPY	20,322	1	2,956,769	0	1,123,101
69.00	06900	ELECTROCARDIOLOGY	2,490	4	456,715	0	44,111
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,118,253	0	231,000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	423,256	0	206,596
73.00	07300	DRUGS CHARGED TO PATIENTS	14,112	8	6,773,696	0	2,015,781
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,110	0	618,651	0	703,833
88.01	08801	RURAL HEALTH CLINIC II	9,307	0	337,874	0	661,003
88.02	08802	RURAL HEALTH CLINIC III	16,518	0	677,951	0	967,799
88.03	08803	RURAL HEALTH CLINIC IV	18,427	25	3,692,910	0	2,824,640
90.00	09000	CLINIC	13,784	17	769,704	0	363,619
91.00	09100	EMERGENCY	35,375	19	5,690,249	0	1,696,546
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	15,468	0	840,659	0	795,322
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	33,048	0	1,852,195	0	1,183,658
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	570,699	340	63,827,678	-2,612,634	27,128,011
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	6,556
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0
194.01	07951	OTHER NONREIMBURSABLE DEPTS	15,820	2	0	0	85,479
194.02	07952	REFERENCE LAB	179	1	0	0	2,726
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,053,369	42,202	593,256		2,612,634
203.00		Unit cost multiplier (Wkst. B, Part I)	1.795419	122.324638	0.009295		0.095972
204.00		Cost to be allocated (per Wkst. B, Part II)	89,517	1,331	67,614		123,316
205.00		Unit cost multiplier (Wkst. B, Part II)	0.152578	3.857971	0.001059		0.004530
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING					5.03
5.04	01160	COMMUNICATIONS					5.04
5.05	00590	BUSINESS OFFICE					5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	99,608				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	121,650			8.00
9.00	00900	HOUSEKEEPING	669	0	96,645		9.00
10.00	01000	DIETARY	3,343	0	3,343	44,148	10.00
11.00	01100	CAFETERIA	1,040	0	1,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,063	0	1,063	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	0	1,505	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	0	1,345	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,285	23,015	9,285	5,569	30.00
44.00	04400	SKILLED NURSING FACILITY	9,791	43,590	9,791	31,035	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,292	8,565	16,292	40	50.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,580	9,220	4,580	0	54.00
57.00	05700	CT SCAN	914	0	914	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	3,521	80	3,521	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,052	0	2,052	0	65.00
66.00	06600	PHYSICAL THERAPY	12,363	13,860	12,363	0	66.00
69.00	06900	ELECTROCARDIOLOGY	728	0	728	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,521	0	3,521	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,318	0	1,318	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,807	0	2,807	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,259	0	4,259	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,413	0	2,413	0	88.03
90.00	09000	CLINIC	6,506	1,000	6,506	81	90.00
91.00	09100	EMERGENCY	4,621	22,320	4,621	504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,350	0	2,350	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,690	121,650	95,727	37,229	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	918	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	0	0	6,919	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,448,621	129,241	562,868	565,732	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.543219	1.062400	5.824078	12.814442	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	199,575	22,078	13,422	47,012	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.003604	0.181488	0.138879	1.064873	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0167

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00550	DATA PROCESSING				5.03
5.04	01160	COMMUNICATIONS				5.04
5.05	00590	BUSINESS OFFICE				5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	110,729			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,531,276		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	127,497	63,827,678	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,940	261,242	2,767,560	30.00
44.00	04400	SKILLED NURSING FACILITY	0	651,870	3,059,449	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,801	226,809	7,917,231	50.00
53.00	05300	ANESTHESIOLOGY	0	7,649	127,273	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,291	5,354,703	54.00
57.00	05700	CT SCAN	0	0	6,882,668	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,235,065	58.00
60.00	06000	LABORATORY	0	537,644	9,861,294	60.00
65.00	06500	RESPIRATORY THERAPY	13,502	16,919	413,553	65.00
66.00	06600	PHYSICAL THERAPY	0	12,716	2,956,769	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,860	456,715	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	162,357	1,118,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	196,728	423,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,837	6,773,696	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,910	618,651	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,105	337,874	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	9,250	677,951	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	7,282	3,692,910	88.03
90.00	09000	CLINIC	8,174	22,216	769,704	90.00
91.00	09100	EMERGENCY	35,312	101,860	5,690,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	23,602	840,659	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	68,478	1,852,195	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,729	2,528,122	63,827,678	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	3,154	0	194.01
194.02	07952	REFERENCE LAB	0	0	0	194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	227,984	151,846	456,156	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.058937	0.059988	0.007147	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,731	19,023	18,869	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.114974	0.007515	0.000296	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
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			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,718,947		2,718,947	0	2,718,947	30.00
44.00	04400	SKILLED NURSING FACILITY	3,643,398		3,643,398	0	3,643,398	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,032,021		2,032,021	0	2,032,021	50.00
53.00	05300	ANESTHESIOLOGY	15,510		15,510	0	15,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,415		1,598,415	4,922	1,603,337	54.00
57.00	05700	CT SCAN	655,837		655,837	0	655,837	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,345		327,345	0	327,345	58.00
60.00	06000	LABORATORY	2,566,950		2,566,950	0	2,566,950	60.00
65.00	06500	RESPIRATORY THERAPY	728,720	0	728,720	0	728,720	65.00
66.00	06600	PHYSICAL THERAPY	1,546,091	0	1,546,091	0	1,546,091	66.00
69.00	06900	ELECTROCARDIOLOGY	66,547		66,547	0	66,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	270,901		270,901	0	270,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,249		241,249	0	241,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,345,285		2,345,285	0	2,345,285	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	802,941		802,941	0	802,941	88.00
88.01	08801	RURAL HEALTH CLINIC II	784,273		784,273	0	784,273	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,152,826		1,152,826	0	1,152,826	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,171,711		3,171,711	0	3,171,711	88.03
90.00	09000	CLINIC	566,528		566,528	0	566,528	90.00
91.00	09100	EMERGENCY	2,144,529		2,144,529	0	2,144,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	583,904		583,904	0	583,904	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	926,939		926,939	0	926,939	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,314,602		1,314,602		1,314,602	116.00
200.00		Subtotal (see instructions)	30,205,469	0	30,205,469	4,922	30,210,391	200.00
201.00		Less Observation Beds	583,904		583,904		583,904	201.00
202.00		Total (see instructions)	29,621,565	0	29,621,565	4,922	29,626,487	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 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	1,949,609		1,949,609			30.00
44.00	04400	SKILLED NURSING FACILITY	3,059,449		3,059,449			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,270,590	6,646,641	7,917,231	0.256658	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	21,745	105,528	127,273	0.121864	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,898	4,965,805	5,354,703	0.298507	0.000000	54.00
57.00	05700	CT SCAN	678,455	6,204,213	6,882,668	0.095288	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,558	1,218,507	1,235,065	0.265043	0.000000	58.00
60.00	06000	LABORATORY	891,352	8,969,942	9,861,294	0.260306	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	84,872	328,681	413,553	1.762096	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	321,384	2,635,385	2,956,769	0.522899	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	45,175	411,540	456,715	0.145708	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	582,110	536,143	1,118,253	0.242254	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,655	371,601	423,256	0.569984	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,225,579	4,548,117	6,773,696	0.346234	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	618,651	618,651			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	337,874	337,874			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	677,951	677,951			88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,908,303	784,607	3,692,910			88.03
90.00	09000	CLINIC	1,104	768,600	769,704	0.736034	0.000000	90.00
91.00	09100	EMERGENCY	701,771	4,988,478	5,690,249	0.376878	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	149,031	668,920	817,951	0.713862	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	840,659	840,659			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,852,195	1,852,195			116.00
200.00		Subtotal (see instructions)	15,347,640	48,480,038	63,827,678			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,347,640	48,480,038	63,827,678			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/28/2022 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
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.256658			50.00
53.00	05300	ANESTHESIOLOGY	0.121864			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.299426			54.00
57.00	05700	CT SCAN	0.095288			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.265043			58.00
60.00	06000	LABORATORY	0.260306			60.00
65.00	06500	RESPIRATORY THERAPY	1.762096			65.00
66.00	06600	PHYSICAL THERAPY	0.522899			66.00
69.00	06900	ELECTROCARDIOLOGY	0.145708			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569984			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346234			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	0.736034			90.00
91.00	09100	EMERGENCY	0.376878			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.713862			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
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			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	2,718,947		2,718,947	0	2,718,947	30.00
44.00	04400	SKILLED NURSING FACILITY	3,643,398		3,643,398	0	3,643,398	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,032,021		2,032,021	0	2,032,021	50.00
53.00	05300	ANESTHESIOLOGY	15,510		15,510	0	15,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,415		1,598,415	4,922	1,603,337	54.00
57.00	05700	CT SCAN	655,837		655,837	0	655,837	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,345		327,345	0	327,345	58.00
60.00	06000	LABORATORY	2,566,950		2,566,950	0	2,566,950	60.00
65.00	06500	RESPIRATORY THERAPY	728,720	0	728,720	0	728,720	65.00
66.00	06600	PHYSICAL THERAPY	1,546,091	0	1,546,091	0	1,546,091	66.00
69.00	06900	ELECTROCARDIOLOGY	66,547		66,547	0	66,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	270,901		270,901	0	270,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,249		241,249	0	241,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,345,285		2,345,285	0	2,345,285	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	802,941		802,941	0	802,941	88.00
88.01	08801	RURAL HEALTH CLINIC II	784,273		784,273	0	784,273	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,152,826		1,152,826	0	1,152,826	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,171,711		3,171,711	0	3,171,711	88.03
90.00	09000	CLINIC	566,528		566,528	0	566,528	90.00
91.00	09100	EMERGENCY	2,144,529		2,144,529	0	2,144,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	583,904		583,904	0	583,904	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	926,939		926,939	0	926,939	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,314,602		1,314,602		1,314,602	116.00
200.00		Subtotal (see instructions)	30,205,469	0	30,205,469	4,922	30,210,391	200.00
201.00		Less Observation Beds	583,904		583,904		583,904	201.00
202.00		Total (see instructions)	29,621,565	0	29,621,565	4,922	29,626,487	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 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
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,949,609		1,949,609			30.00	
44.00	04400	SKILLED NURSING FACILITY	3,059,449		3,059,449			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,270,590	6,646,641	7,917,231	0.256658	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	21,745	105,528	127,273	0.121864	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,898	4,965,805	5,354,703	0.298507	0.000000	54.00	
57.00	05700	CT SCAN	678,455	6,204,213	6,882,668	0.095288	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,558	1,218,507	1,235,065	0.265043	0.000000	58.00	
60.00	06000	LABORATORY	891,352	8,969,942	9,861,294	0.260306	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	84,872	328,681	413,553	1.762096	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	321,384	2,635,385	2,956,769	0.522899	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	45,175	411,540	456,715	0.145708	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	582,110	536,143	1,118,253	0.242254	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,655	371,601	423,256	0.569984	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,225,579	4,548,117	6,773,696	0.346234	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	618,651	618,651	1.297890	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	337,874	337,874	2.321200	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	677,951	677,951	1.700456	0.000000	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	2,908,303	784,607	3,692,910	0.858865	0.000000	88.03	
90.00	09000	CLINIC	1,104	768,600	769,704	0.736034	0.000000	90.00	
91.00	09100	EMERGENCY	701,771	4,988,478	5,690,249	0.376878	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	149,031	668,920	817,951	0.713862	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
101.00	10100	HOME HEALTH AGENCY	0	840,659	840,659			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	1,852,195	1,852,195			116.00	
200.00		Subtotal (see instructions)	15,347,640	48,480,038	63,827,678			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	15,347,640	48,480,038	63,827,678			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 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
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.256658		50.00
53.00	05300	ANESTHESIOLOGY	0.121864		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.299426		54.00
57.00	05700	CT SCAN	0.095288		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.265043		58.00
60.00	06000	LABORATORY	0.260306		60.00
65.00	06500	RESPIRATORY THERAPY	1.762096		65.00
66.00	06600	PHYSICAL THERAPY	0.522899		66.00
69.00	06900	ELECTROCARDIOLOGY	0.145708		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569984		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346234		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.297890		88.00
88.01	08801	RURAL HEALTH CLINIC II	2.321200		88.01
88.02	08802	RURAL HEALTH CLINIC III	1.700456		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.858865		88.03
90.00	09000	CLINIC	0.736034		90.00
91.00	09100	EMERGENCY	0.376878		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.713862		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description			Title XIX		Hospital		PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,032,021	357,849	1,674,172	0	0	50.00
53.00	05300	ANESTHESIOLOGY	15,510	1,946	13,564	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,415	150,770	1,447,645	0	0	54.00
57.00	05700	CT SCAN	655,837	110,327	545,510	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,345	3,989	323,356	0	0	58.00
60.00	06000	LABORATORY	2,566,950	129,937	2,437,013	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	728,720	44,588	684,132	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,546,091	153,436	1,392,655	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	66,547	12,970	53,577	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	270,901	4,168	266,733	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,249	3,337	237,912	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,345,285	62,592	2,282,693	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	802,941	30,473	772,468	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	784,273	46,438	737,835	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,152,826	59,454	1,093,372	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,171,711	56,376	3,115,335	0	0	88.03
90.00	09000	CLINIC	566,528	68,574	497,954	0	0	90.00
91.00	09100	EMERGENCY	2,144,529	105,551	2,038,978	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	583,904	36,664	547,240	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	926,939	43,342	883,597	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,314,602	76,126	1,238,476	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	23,843,124	1,558,907	22,284,217	0	0	200.00
201.00		Less Observation Beds	583,904	36,664	547,240	0	0	201.00
202.00		Total (line 200 minus line 201)	23,259,220	1,522,243	21,736,977	0	0	202.00

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

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
2/28/2022 11:01 am

				Title XIX		Hospital		PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)				
		6.00							
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,032,021	7,917,231	0.256658			50.00	
53.00	05300	ANESTHESIOLOGY	15,510	127,273	0.121864			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,415	5,354,703	0.298507			54.00	
57.00	05700	CT SCAN	655,837	6,882,668	0.095288			57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,345	1,235,065	0.265043			58.00	
60.00	06000	LABORATORY	2,566,950	9,861,294	0.260306			60.00	
65.00	06500	RESPIRATORY THERAPY	728,720	413,553	1.762096			65.00	
66.00	06600	PHYSICAL THERAPY	1,546,091	2,956,769	0.522899			66.00	
69.00	06900	ELECTROCARDIOLOGY	66,547	456,715	0.145708			69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	270,901	1,118,253	0.242254			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,249	423,256	0.569984			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,345,285	6,773,696	0.346234			73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	802,941	618,651	1.297890			88.00	
88.01	08801	RURAL HEALTH CLINIC II	784,273	337,874	2.321200			88.01	
88.02	08802	RURAL HEALTH CLINIC III	1,152,826	677,951	1.700456			88.02	
88.03	08803	RURAL HEALTH CLINIC IV	3,171,711	3,692,910	0.858865			88.03	
90.00	09000	CLINIC	566,528	769,704	0.736034			90.00	
91.00	09100	EMERGENCY	2,144,529	5,690,249	0.376878			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	583,904	817,951	0.713862			92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000			95.00	
101.00	10100	HOME HEALTH AGENCY	926,939	840,659	1.102634			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	1,314,602	1,852,195	0.709754			116.00	
200.00		Subtotal (sum of lines 50 thru 199)	23,843,124	58,818,620				200.00	
201.00		Less Observation Beds	583,904	0				201.00	
202.00		Total (line 200 minus line 201)	23,259,220	58,818,620				202.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 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	170,728	0	170,728	1,830	93.29	30.00	
44.00	SKILLED NURSING FACILITY	184,467		184,467	10,540	17.50	44.00	
200.00	Total (lines 30 through 199)	355,195		355,195	12,370		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	868	80,976					30.00
44.00	SKILLED NURSING FACILITY	620	10,850					44.00
200.00	Total (lines 30 through 199)	1,488	91,826					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 11:01 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	357,849	7,917,231	0.045199	909,974	41,130	50.00
53.00	05300	ANESTHESIOLOGY	1,946	127,273	0.015290	16,946	259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,770	5,354,703	0.028157	337,254	9,496	54.00
57.00	05700	CT SCAN	110,327	6,882,668	0.016030	678,455	10,876	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,989	1,235,065	0.003230	16,558	53	58.00
60.00	06000	LABORATORY	129,937	9,861,294	0.013176	876,516	11,549	60.00
65.00	06500	RESPIRATORY THERAPY	44,588	413,553	0.107817	52,046	5,611	65.00
66.00	06600	PHYSICAL THERAPY	153,436	2,956,769	0.051893	110,648	5,742	66.00
69.00	06900	ELECTROCARDIOLOGY	12,970	456,715	0.028398	44,426	1,262	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,168	1,118,253	0.003727	425,676	1,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,337	423,256	0.007884	51,655	407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,592	6,773,696	0.009240	1,278,545	11,814	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	30,473	618,651	0.049257	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	46,438	337,874	0.137442	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	59,454	677,951	0.087697	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	56,376	3,692,910	0.015266	0	0	88.03
90.00	09000	CLINIC	68,574	769,704	0.089091	638	57	90.00
91.00	09100	EMERGENCY	105,551	5,690,249	0.018549	475,621	8,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,664	817,951	0.044824	149,031	6,680	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,439,439	56,125,766		5,423,989	115,344	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/28/2022 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	
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	1,830	0.00	868		30.00	
44.00	04400	SKILLED NURSING FACILITY			0	10,540	0.00	620		44.00	
200.00		Total (lines 30 through 199)			0	12,370		1,488		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
44.00	04400	SKILLED NURSING FACILITY		0						44.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 11:01 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

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

Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 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	7,917,231	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	127,273	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,354,703	0.000000 54.00
57.00	05700	CT SCAN	0	0	0	6,882,668	0.000000 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,235,065	0.000000 58.00
60.00	06000	LABORATORY	0	0	0	9,861,294	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	413,553	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,956,769	0.000000 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	456,715	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,118,253	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	423,256	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,773,696	0.000000 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	618,651	0.000000 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	337,874	0.000000 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	677,951	0.000000 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	3,692,910	0.000000 88.03
90.00	09000	CLINIC	0	0	0	769,704	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	5,690,249	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	817,951	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	56,125,766	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 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	909,974	0	2,189,845	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	16,946	0	25,803	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	337,254	0	1,643,523	0	54.00
57.00	05700	CT SCAN	0.000000	678,455	0	2,015,795	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	16,558	0	447,807	0	58.00
60.00	06000	LABORATORY	0.000000	876,516	0	1,184,651	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	52,046	0	152,578	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	110,648	0	9,197	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	44,426	0	158,875	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	425,676	0	186,859	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	51,655	0	203,020	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,278,545	0	883,312	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	638	0	400,188	0	90.00
91.00	09100	EMERGENCY	0.000000	475,621	0	1,230,914	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	149,031	0	253,694	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,423,989	0	10,986,061	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 11:01 am

				Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.256658	2,189,845	0	0	562,041	50.00		
53.00	05300	ANESTHESIOLOGY	0.121864	25,803	0	0	3,144	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.298507	1,643,523	0	0	490,603	54.00		
57.00	05700	CT SCAN	0.095288	2,015,795	0	0	192,081	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.265043	447,807	0	0	118,688	58.00		
60.00	06000	LABORATORY	0.260306	1,184,651	10,514	0	308,372	60.00		
65.00	06500	RESPIRATORY THERAPY	1.762096	152,578	0	0	268,857	65.00		
66.00	06600	PHYSICAL THERAPY	0.522899	9,197	0	0	4,809	66.00		
69.00	06900	ELECTROCARDIOLOGY	0.145708	158,875	0	0	23,149	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254	186,859	0	0	45,267	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569984	203,020	0	0	115,718	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346234	883,312	0	20,302	305,833	73.00		
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC						88.00		
88.01	08801	RURAL HEALTH CLINIC II						88.01		
88.02	08802	RURAL HEALTH CLINIC III						88.02		
88.03	08803	RURAL HEALTH CLINIC IV						88.03		
90.00	09000	CLINIC	0.736034	400,188	0	0	294,552	90.00		
91.00	09100	EMERGENCY	0.376878	1,230,914	0	150	463,904	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.713862	253,694	0	0	181,103	92.00		
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00		
200.00		Subtotal (see instructions)		10,986,061	10,514	20,452	3,378,121	200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00		
202.00		Net Charges (line 200 - line 201)		10,986,061	10,514	20,452	3,378,121	202.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 2/28/2022 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
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	2,737	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,029					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II							88.01
88.02	08802	RURAL HEALTH CLINIC III							88.02
88.03	08803	RURAL HEALTH CLINIC IV							88.03
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	57					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	2,737	7,086					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	2,737	7,086					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 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	170,728	0	170,728	1,830	93.29	30.00	
44.00	SKILLED NURSING FACILITY	184,467		184,467	10,540	17.50	44.00	
200.00	Total (lines 30 through 199)	355,195		355,195	12,370		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	6	560					30.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	6	560					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	357,849	7,917,231	0.045199	12,622	571 50.00
53.00	05300	ANESTHESIOLOGY	1,946	127,273	0.015290	578	9 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,770	5,354,703	0.028157	1,888	53 54.00
57.00	05700	CT SCAN	110,327	6,882,668	0.016030	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,989	1,235,065	0.003230	0	0 58.00
60.00	06000	LABORATORY	129,937	9,861,294	0.013176	7,190	95 60.00
65.00	06500	RESPIRATORY THERAPY	44,588	413,553	0.107817	206	22 65.00
66.00	06600	PHYSICAL THERAPY	153,436	2,956,769	0.051893	413	21 66.00
69.00	06900	ELECTROCARDIOLOGY	12,970	456,715	0.028398	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,168	1,118,253	0.003727	2,341	9 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,337	423,256	0.007884	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,592	6,773,696	0.009240	9,238	85 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	30,473	618,651	0.049257	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	46,438	337,874	0.137442	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	59,454	677,951	0.087697	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	56,376	3,692,910	0.015266	0	0 88.03
90.00	09000	CLINIC	68,574	769,704	0.089091	0	0 90.00
91.00	09100	EMERGENCY	105,551	5,690,249	0.018549	1,646	31 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,664	817,951	0.044824	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	1,439,439	56,125,766		36,122	896 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0167		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/28/2022 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	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,830	0.00	6	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	10,540	0.00	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	12,370		6	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
44.00	04400	SKILLED NURSING FACILITY	0	0						44.00
200.00		Total (lines 30 through 199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		Title XIX		Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	7,917,231	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	127,273	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	5,354,703	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	6,882,668	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,235,065	0.000000	58.00
60.00	06000 LABORATORY	0	0	0	9,861,294	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	413,553	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	2,956,769	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	456,715	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,118,253	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	423,256	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	6,773,696	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	618,651	0.000000	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	337,874	0.000000	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	677,951	0.000000	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0	3,692,910	0.000000	88.03
90.00	09000 CLINIC	0	0	0	769,704	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	5,690,249	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	817,951	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	0	56,125,766		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		Title XIX		Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	12,622	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	578	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,888	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	7,190	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	206	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	413	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,341	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,238	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,646	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		36,122	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 11:01 am

			Title XIX		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.256658	0	89,885	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.121864	0	2,392	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.298507	0	60,755	0	0	54.00
57.00	05700	CT SCAN	0.095288	0	96,529	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.265043	0	26,355	0	0	58.00
60.00	06000	LABORATORY	0.260306	0	96,758	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.762096	0	1,230	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.522899	0	78,411	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.145708	0	12,381	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254	0	5,211	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569984	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.346234	0	23,097	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.736034	0	13,882	0	0	90.00
91.00	09100	EMERGENCY	0.376878	0	77,284	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.713862	0	33,816	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	617,986	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	617,986	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 11:01 am

			Title XIX		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	23,070	0		50.00
53.00	05300	ANESTHESIOLOGY	291	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,136	0		54.00
57.00	05700	CT SCAN	9,198	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,985	0		58.00
60.00	06000	LABORATORY	25,187	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,167	0		65.00
66.00	06600	PHYSICAL THERAPY	41,001	0		66.00
69.00	06900	ELECTROCARDIOLOGY	1,804	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,262	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,997	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	10,218	0		90.00
91.00	09100	EMERGENCY	29,127	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,140	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	200,583	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	200,583	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 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)			1,830	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,830	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)			1,437	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			868	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,718,947	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,718,947	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,718,947	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)			1,485.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,289,640	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,289,640	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,651,191	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,940,831	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)					80,976	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					115,344	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					196,320	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,744,511	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)					393	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,485.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					583,904	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 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	170,728	2,718,947	0.062792	583,904	36,664	90.00
91.00 Nursing Program cost	0	2,718,947	0.000000	583,904	0	91.00
92.00 Allied health cost	0	2,718,947	0.000000	583,904	0	92.00
93.00 All other Medical Education	0	2,718,947	0.000000	583,904	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:01 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,540	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		10,540	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		620	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,643,398	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,643,398	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,643,398	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:01 am	
				Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					3,643,398	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					345.67	71.00
72.00	Program routine service cost (line 9 x line 71)					214,315	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					214,315	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					214,315	83.00
84.00	Program inpatient ancillary services (see instructions)					7,704	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					222,019	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

Period:

Worksheet D-1

Component CCN: 14-6049

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:01 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,830	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,830	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)		1,437	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,718,947	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,718,947	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,718,947	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)		1,485.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,915	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)		8,915	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 11:01 am

		Title XIX		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					10,712	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,627	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)					560	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					896	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,456	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,171	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)					393	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,485.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					583,904	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0167

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	170,728	2,718,947	0.062792	583,904	36,664 90.00
91.00	Nursing Program cost	0	2,718,947	0.000000	583,904	0 91.00
92.00	Allied health cost	0	2,718,947	0.000000	583,904	0 92.00
93.00	All other Medical Education	0	2,718,947	0.000000	583,904	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 11:01 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,122,958		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.256658	909,974	233,552	50.00
53.00	05300 ANESTHESIOLOGY	0.121864	16,946	2,065	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.299426	337,254	100,983	54.00
57.00	05700 CT SCAN	0.095288	678,455	64,649	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.265043	16,558	4,389	58.00
60.00	06000 LABORATORY	0.260306	876,516	228,162	60.00
65.00	06500 RESPIRATORY THERAPY	1.762096	52,046	91,710	65.00
66.00	06600 PHYSICAL THERAPY	0.522899	110,648	57,858	66.00
69.00	06900 ELECTROCARDIOLOGY	0.145708	44,426	6,473	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254	425,676	103,122	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.569984	51,655	29,443	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.346234	1,278,545	442,676	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000 CLINIC	0.736034	638	470	90.00
91.00	09100 EMERGENCY	0.376878	475,621	179,251	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.713862	149,031	106,388	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,423,989	1,651,191	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		5,423,989		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 11:01 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.256658	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.121864	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.299426	0	0	54.00
57.00	05700 CT SCAN	0.095288	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.265043	0	0	58.00
60.00	06000 LABORATORY	0.260306	54	14	60.00
65.00	06500 RESPIRATORY THERAPY	1.762096	288	507	65.00
66.00	06600 PHYSICAL THERAPY	0.522899	6,860	3,587	66.00
69.00	06900 ELECTROCARDIOLOGY	0.145708	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254	474	115	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.569984	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.346234	10,055	3,481	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000 CLINIC	0.736034	0	0	90.00
91.00	09100 EMERGENCY	0.376878	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.713862	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		17,731	7,704	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)		17,731		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 11:01 am	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,042		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.256658	12,622	3,240	50.00
53.00	05300 ANESTHESIOLOGY	0.121864	578	70	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.299426	1,888	565	54.00
57.00	05700 CT SCAN	0.095288	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.265043	0	0	58.00
60.00	06000 LABORATORY	0.260306	7,190	1,872	60.00
65.00	06500 RESPIRATORY THERAPY	1.762096	206	363	65.00
66.00	06600 PHYSICAL THERAPY	0.522899	413	216	66.00
69.00	06900 ELECTROCARDIOLOGY	0.145708	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.242254	2,341	567	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.569984	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.346234	9,238	3,199	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.297890	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	2.321200	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1.700456	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.858865	0	0	88.03
90.00	09000 CLINIC	0.736034	0	0	90.00
91.00	09100 EMERGENCY	0.376878	1,646	620	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.713862	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		36,122	10,712	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		36,122		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 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)		1,866,579	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)		84,198	2.04
3.00	Managed Care Simulated Payments		360,440	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		23.92	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)		6.52	30.00
31.00	Percentage of Medicaid patient days (see instructions)		9.95	31.00
32.00	Sum of lines 30 and 31		16.47	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.46	33.00
34.00	Disproportionate share adjustment (see instructions)		16,146	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 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	0.000035337		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	292,944	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	292,944	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		292,944		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)		2,259,867		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		2,351,452		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			2,351,452	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			144,920	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			137,788	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,634,160	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,634,160	61.00
62.00	Deductibles billed to program beneficiaries			261,380	62.00
63.00	Coinsurance billed to program beneficiaries			2,502	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,370,278	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-200	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 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)	2021	678,296	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		33,123	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,015,251	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		3,052,682	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)		-37,431	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		26,164	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2022 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	1,866,579	0	0	1,866,579	1,866,579
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	84,198	0	0	84,198	84,198
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	360,440	0	0	360,440	360,440
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0346	0.0346	0.0346	0.0346	0
11.00	Disproportionate share adjustment (see instructions)	34.00	16,146	0	0	16,146	16,146
11.01	Uncompensated care payments	36.00	292,944	0	0	292,944	292,944
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	2,259,867	0	0	2,259,867	2,259,867
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,351,452	0	0	2,351,452	2,351,452
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,351,452	0	0	2,351,452	2,351,452
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	144,920	0	0	144,920	144,920

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2022 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	
17.00	Special add-on payments for new technologies	54.00	137,788	0	0	137,788	137,788	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	2,634,160	2,634,160	19.00
		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	138,852	0	0	138,852	138,852	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,068	0	0	6,068	6,068	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	144,920	0	0	144,920	144,920	26.00
		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	0.257500		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				678,296	678,296	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/28/2022 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	1,866,579		1,866,579	1,866,579	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	84,198		84,198	84,198	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	360,440	0	360,440	360,440	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	0.0346	0.0346	0.0346		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	16,146	0	16,146	16,146	11.00
11.01	Uncompensated care payments	36.00	292,944	0	292,944	292,944	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	2,259,867	0	2,259,867	2,259,867	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,351,452	0	2,351,452	2,351,452	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,351,452	0	2,351,452	2,351,452	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	144,920	0	144,920	144,920	16.00
17.00	Special add-on payments for new technologies	54.00	137,788	0	137,788	137,788	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,634,160	2,634,160	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/28/2022 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	138,852	0	138,852	138,852	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	6,068	0	6,068	6,068	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	144,920	0	144,920	144,920	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	678,296		678,296	678,296	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-200	0	-200	-200	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	33,123	33,123	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 11:01 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			9,823	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			3,378,121	2.00
3.00	OPPS payments			2,047,495	3.00
4.00	Outlier payment (see instructions)			41,137	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			9,823	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			30,966	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)			30,966	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)			30,966	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			21,143	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			9,823	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			2,088,632	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)			410,279	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,688,176	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			1,688,176	30.00
31.00	Primary payer payments			366	31.00
32.00	Subtotal (line 30 minus line 31)			1,687,810	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)			8,434	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			5,482	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	36.00
37.00	Subtotal (see instructions)			1,693,292	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			1,693,292	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			1,683,934	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)			9,358	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			17,552	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 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		3,079,570		1,683,934	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		7,148		20,012	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	06/30/2021	34,036	06/30/2021	20,012	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)		-34,036		-20,012	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)		3,052,682		1,683,934	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		9,358	6.01
6.02	SETTLEMENT TO PROGRAM		37,431		0	6.02
7.00	Total Medicare program liability (see instructions)		3,015,251		1,693,292	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0167

Period:

Worksheet E-1

Component CCN: 14-6049

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		322,930		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)		322,930		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)		322,930		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/28/2022 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 from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167 Component CCN: 14-6049	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2022 11:01 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			368,830 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			368,830 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			45,900 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			322,930 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			322,930 15.00
15.01	Sequestration adjustment (see instructions)			0 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			322,930 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2022 11:01 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			200,583	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	200,583	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	200,583	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		36,122	617,986	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		36,122	617,986	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		36,122	617,986	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		36,122	417,403	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	200,583	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	200,583	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	200,583	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	200,583	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	200,583	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	200,583	40.00
41.00	Interim payments		0	200,583	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-0167

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

Worksheet G

Date/Time Prepared:
2/28/2022 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	2,980,766	0	0	0	1.00
2.00	Temporary investments	24,625	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,220,137	0	0	0	4.00
5.00	Other receivable	670,758	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,607,412	0	0	0	6.00
7.00	Inventory	886,544	0	0	0	7.00
8.00	Prepaid expenses	434,696	0	0	0	8.00
9.00	Other current assets	22	0	0	0	9.00
10.00	Due from other funds	261,645	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,871,781	0	0	0	11.00
FIXED ASSETS						
12.00	Land	332,950	0	0	0	12.00
13.00	Land improvements	483,750	0	0	0	13.00
14.00	Accumulated depreciation	-481,023	0	0	0	14.00
15.00	Buildings	26,544,252	0	0	0	15.00
16.00	Accumulated depreciation	-19,922,832	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	16,726,644	0	0	0	19.00
20.00	Accumulated depreciation	-15,537,432	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,146,309	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,381,293	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,381,293	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,399,383	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,977,548	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,330,642	0	0	0	38.00
39.00	Payroll taxes payable	92,770	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,207,541	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,608,501	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,121,465	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,121,465	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,729,966	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,669,417				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)	11,669,417	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,399,383	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0167

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

Worksheet G-1

Date/Time Prepared:
2/28/2022 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		4,788,391		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,881,026				2.00
3.00	Total (sum of line 1 and line 2)		11,669,417		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,669,417		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,669,417		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0167

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 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	3,365,151		3,365,151	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	5,967,752		5,967,752	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,332,903		9,332,903	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,332,903		9,332,903	17.00
18.00	Ancillary services	695,975	49,280,159	49,976,134	18.00
19.00	Outpatient services	0	2,268	2,268	19.00
20.00	RURAL HEALTH CLINIC	0	618,651	618,651	20.00
20.01	RURAL HEALTH CLINIC II	0	337,874	337,874	20.01
20.02	RURAL HEALTH CLINIC III	0	677,951	677,951	20.02
20.03	RURAL HEALTH CLINIC IV	0	784,607	784,607	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		840,659	840,659	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,852,195	1,852,195	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)	10,028,878	54,394,364	64,423,242	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,661,770		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)		33,661,770		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0167

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

Worksheet G-3

Date/Time Prepared:
2/28/2022 11:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,423,242	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,432,758	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,990,484	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,661,770	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,671,286	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	146,268	6.00
7.00	Income from investments	382,384	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	102,535	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	84,327	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B INCOME/LOSS	0	24.00
24.01	MISC NON-PATIENT REVENUE	273,790	24.01
24.02	AMBULANCE SUBSIDY	0	24.02
24.03	OTHER MISCELLANEOUS REVENUE	707	24.03
24.04	OTHER MISCELLANEOUS REVENUE	8,562,301	24.04
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	9,552,312	25.00
26.00	Total (line 5 plus line 25)	6,881,026	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,881,026	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0167

Period:

Worksheet H

HHA CCN: 14-7586

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 11:01 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	29,751	0	0	29,751	4.00
5.00	Administrative and General	126,877	120	0	32,288	23,247	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	275,820	261	0	0	276,081	6.00
7.00	Physical Therapy	71,713	68	0	0	71,781	7.00
8.00	Occupational Therapy	11,033	10	0	0	11,043	8.00
9.00	Speech Pathology	1,103	1	0	0	1,104	9.00
10.00	Medical Social Services	441	0	0	0	441	10.00
11.00	Home Health Aide	64,653	61	0	0	64,714	11.00
12.00	Supplies (see instructions)	0	0	0	23,602	23,602	12.00
13.00	Drugs	0	0	0	54	54	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	551,640	521	29,751	32,288	46,903	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	-24,851	4,900	0	4,900		4.00
5.00	Administrative and General	0	182,532	0	182,532		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	276,081	0	276,081		6.00
7.00	Physical Therapy	0	71,781	0	71,781		7.00
8.00	Occupational Therapy	0	11,043	0	11,043		8.00
9.00	Speech Pathology	0	1,104	0	1,104		9.00
10.00	Medical Social Services	0	441	0	441		10.00
11.00	Home Health Aide	0	64,714	0	64,714		11.00
12.00	Supplies (see instructions)	0	23,602	0	23,602		12.00
13.00	Drugs	0	54	0	54		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-24,851	636,252	0	636,252		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0167

Period:

Worksheet H-1

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	4,900	0	0	0	4,900		4.00
5.00	Administrative and General	182,532	0	0	0	4,900	187,432	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	276,081	0	0	0	0	276,081	6.00
7.00	Physical Therapy	71,781	0	0	0	0	71,781	7.00
8.00	Occupational Therapy	11,043	0	0	0	0	11,043	8.00
9.00	Speech Pathology	1,104	0	0	0	0	1,104	9.00
10.00	Medical Social Services	441	0	0	0	0	441	10.00
11.00	Home Health Aide	64,714	0	0	0	0	64,714	11.00
12.00	Supplies (see instructions)	23,602	0	0	0	0	23,602	12.00
13.00	Drugs	54	0	0	0	0	54	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	636,252	0	0	0	4,900	636,252	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	187,432						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	115,294	391,375					6.00
7.00	Physical Therapy	29,977	101,758					7.00
8.00	Occupational Therapy	4,612	15,655					8.00
9.00	Speech Pathology	461	1,565					9.00
10.00	Medical Social Services	184	625					10.00
11.00	Home Health Aide	27,025	91,739					11.00
12.00	Supplies (see instructions)	9,856	33,458					12.00
13.00	Drugs	23	77					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		636,252					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-1

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,350			0		1.00
2.00	Capital Related - Movable Equipment		28,165		0		2.00
3.00	Plant Operation & Maintenance	0	0	2,350	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	2,350	28,165	2,350	100	-187,432	448,820
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	276,081	6.00
7.00	Physical Therapy	0	0	0	0	71,781	7.00
8.00	Occupational Therapy	0	0	0	0	11,043	8.00
9.00	Speech Pathology	0	0	0	0	1,104	9.00
10.00	Medical Social Services	0	0	0	0	441	10.00
11.00	Home Health Aide	0	0	0	0	64,714	11.00
12.00	Supplies (see instructions)	0	0	0	0	23,602	12.00
13.00	Drugs	0	0	0	0	54	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,350	28,165	2,350	100	-187,432	448,820
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	4,900		187,432
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	49.000000		0.417611

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2020

Part I

To 09/30/2021

Date/Time Prepared:

2/28/2022 11:01 am

Home Health

PPS

Agency I

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	16,157	14,190	20,543	3,308	512	1.00
2.00	Skilled Nursing Care	391,375	0	0	44,659	0	0	2.00
3.00	Physical Therapy	101,758	0	0	11,611	0	0	3.00
4.00	Occupational Therapy	15,655	0	0	1,786	0	0	4.00
5.00	Speech Pathology	1,565	0	0	179	0	0	5.00
6.00	Medical Social Services	625	0	0	71	0	0	6.00
7.00	Home Health Aide	91,739	0	0	10,468	0	0	7.00
8.00	Supplies (see instructions)	33,458	0	0	0	0	0	8.00
9.00	Drugs	77	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	636,252	16,157	14,190	89,317	3,308	512	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	5A.05	5.06	7.00	
1.00	Administrative and General	27,772	0	7,814	90,296	8,666	34,177	1.00
2.00	Skilled Nursing Care	0	0	0	436,034	41,848	0	2.00
3.00	Physical Therapy	0	0	0	113,369	10,880	0	3.00
4.00	Occupational Therapy	0	0	0	17,441	1,674	0	4.00
5.00	Speech Pathology	0	0	0	1,744	167	0	5.00
6.00	Medical Social Services	0	0	0	696	67	0	6.00
7.00	Home Health Aide	0	0	0	102,207	9,809	0	7.00
8.00	Supplies (see instructions)	0	0	0	33,458	3,211	0	8.00
9.00	Drugs	0	0	0	77	7	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	27,772	0	7,814	795,322	76,329	34,177	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	13,687	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	1,416	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	13,687	0	0	0	1,416	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	6,008	152,834	0	152,834			1.00
2.00	Skilled Nursing Care	0	477,882	0	477,882	94,349	572,231	2.00
3.00	Physical Therapy	0	124,249	0	124,249	24,531	148,780	3.00
4.00	Occupational Therapy	0	19,115	0	19,115	3,774	22,889	4.00
5.00	Speech Pathology	0	1,911	0	1,911	377	2,288	5.00
6.00	Medical Social Services	0	763	0	763	151	914	6.00
7.00	Home Health Aide	0	112,016	0	112,016	22,116	134,132	7.00
8.00	Supplies (see instructions)	0	38,085	0	38,085	7,519	45,604	8.00
9.00	Drugs	0	84	0	84	17	101	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	6,008	926,939	0	926,939	152,834	926,939	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.197433		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	DATA PROCESSING (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	2,350	28,165	125,133	840,659	23,602	15,468	1.00
2.00	Skilled Nursing Care	0	0	272,028	0	0	0	2.00
3.00	Physical Therapy	0	0	70,727	0	0	0	3.00
4.00	Occupational Therapy	0	0	10,881	0	0	0	4.00
5.00	Speech Pathology	0	0	1,088	0	0	0	5.00
6.00	Medical Social Services	0	0	435	0	0	0	6.00
7.00	Home Health Aide	0	0	63,764	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,350	28,165	544,056	840,659	23,602	15,468	20.00
21.00	Total cost to be allocated	16,157	14,190	89,317	3,308	512	27,772	21.00
22.00	Unit cost multiplier	6.875319	0.503817	0.164169	0.003935	0.021693	1.795449	22.00
Cost Center Description		COMMUNICATIONS	BUSINESS OFFICE	Reconciliation	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		(# OF PHONES)	(GROSS CHARGES)		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	
		5.04	5.05	5A.06	5.06	7.00	8.00	
1.00	Administrative and General	0	840,659	0	90,296	2,350	0	1.00
2.00	Skilled Nursing Care	0	0	0	436,034	0	0	2.00
3.00	Physical Therapy	0	0	0	113,369	0	0	3.00
4.00	Occupational Therapy	0	0	0	17,441	0	0	4.00
5.00	Speech Pathology	0	0	0	1,744	0	0	5.00
6.00	Medical Social Services	0	0	0	696	0	0	6.00
7.00	Home Health Aide	0	0	0	102,207	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	33,458	0	0	8.00
9.00	Drugs	0	0	0	77	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	840,659		795,322	2,350	0	20.00
21.00	Total cost to be allocated	0	7,814		76,329	34,177	0	21.00
22.00	Unit cost multiplier	0.000000	0.009295		0.095972	14.543404	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0167

Period:

Worksheet H-2

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 amHome Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	2,350	0	0	0	0	840,659	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	23,602	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,350	0	0	0	23,602	840,659	20.00
21.00	Total cost to be allocated	13,687	0	0	0	1,416	6,008	21.00
22.00	Unit cost multiplier	5.824255	0.000000	0.000000	0.000000	0.059995	0.007147	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	572,231		572,231	2,834	201.92	1.00
2.00	Physical Therapy	3.00	148,780	0	148,780	1,254	118.64	2.00
3.00	Occupational Therapy	4.00	22,889	0	22,889	363	63.06	3.00
4.00	Speech Pathology	5.00	2,288	0	2,288	27	84.74	4.00
5.00	Medical Social Services	6.00	914		914	15	60.93	5.00
6.00	Home Health Aide	7.00	134,132		134,132	434	309.06	6.00
7.00	Total (sum of lines 1-6)		881,234	0	881,234	4,927		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		16580	0	47			8.00
8.01	Skilled Nursing Care		19180	0	177			8.01
8.02	Skilled Nursing Care		99914	0	1,601			8.02
9.00	Physical Therapy		16580	0	19			9.00
9.01	Physical Therapy		19180	0	28			9.01
9.02	Physical Therapy		99914	0	836			9.02
10.00	Occupational Therapy		16580	0	1			10.00
10.01	Occupational Therapy		19180	0	6			10.01
10.02	Occupational Therapy		99914	0	246			10.02
11.00	Speech Pathology		16580	0	0			11.00
11.01	Speech Pathology		19180	0	4			11.01
11.02	Speech Pathology		99914	0	8			11.02
12.00	Medical Social Services		16580	0	0			12.00
12.01	Medical Social Services		19180	0	0			12.01
12.02	Medical Social Services		99914	0	12			12.02
13.00	Home Health Aide		16580	0	0			13.00
13.01	Home Health Aide		19180	0	0			13.01
13.02	Home Health Aide		99914	0	351			13.02
14.00	Total (sum of lines 8-13)			0	3,336			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	45,604	0	45,604	0	0.000000	15.00
16.00	Cost of Drugs	9.00	101	0	101	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
6.00	7.00	8.00	9.00	10.00	11.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,825		0	368,504		1.00
2.00	Physical Therapy	0	883		0	104,759		2.00
3.00	Occupational Therapy	0	253		0	15,954		3.00
4.00	Speech Pathology	0	12		0	1,017		4.00
5.00	Medical Social Services	0	12		0	731		5.00
6.00	Home Health Aide	0	351		0	108,480		6.00
7.00	Total (sum of lines 1-6)	0	3,336		0	599,445		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1		
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	24,227	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	368,504						1.00
2.00	Physical Therapy	104,759						2.00
3.00	Occupational Therapy	15,954						3.00
4.00	Speech Pathology	1,017						4.00
5.00	Medical Social Services	731						5.00
6.00	Home Health Aide	108,480						6.00
7.00	Total (sum of lines 1-6)	599,445						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet H-3

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.522899	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.242254	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.346234	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0167 HHA CCN: 14-7586	Period: From 10/01/2020 To 09/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2022 11:01 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	483,041
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	54,231
13.00	Total PPS Reimbursement - LUPA Episodes		0	9,046
14.00	Total PPS Reimbursement - PEP Episodes		0	717
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	14,051
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	561,086
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	561,086
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	561,086
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	561,086
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	561,086
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	561,086
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-0167

Period:

Worksheet H-5

HHA CCN: 14-7586

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 amHome Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		561,086	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		561,086	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		561,086	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

				Hospice I		2/28/2022 11:01 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	9,176	9,176	0	9,176	3.00
4.00	ADMINISTRATIVE & GENERAL*	195,993	46,251	242,244	0	242,244	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	14,773	14,773	0	14,773	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*	63,157	0	63,157	0	63,157	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	11,908	11,908	-7,008	4,900	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	80,273	80,273	0	80,273	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	55	0	55	0	55	27.00
28.00	REGISTERED NURSE**	8,984	0	8,984	0	8,984	28.00
29.00	LPN/LVN**	296,669	0	296,669	0	296,669	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	1,007	0	1,007	0	1,007	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	118,763	0	118,763	0	118,763	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	35,078	35,078	0	35,078	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	97,435	97,435	0	97,435	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	684,628	294,894	979,522	-7,008	972,514	100.00

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

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 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	9,176		3.00
4.00	ADMINISTRATIVE & GENERAL*	-1,026	241,218		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	14,773		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	63,157		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	4,900		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	80,273		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	0		26.00
27.00	NURSE PRACTITIONER**	0	55		27.00
28.00	REGISTERED NURSE**	0	8,984		28.00
29.00	LPN/LVN**	0	296,669		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	1,007		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	118,763		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	35,078		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	97,435		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-1,026	971,488		100.00

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

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

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

Provider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2020
To 09/30/2021Worksheet 0-2
Date/Time Prepared:
2/28/2022 11:01 am

				Hospice I		2/26/2022 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						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	6,467	0	6,467	0	6,467	28.00
29.00	LPN/LVN	296,669	0	296,669	0	296,669	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	118,763	0	118,763	0	118,763	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	34,783	34,783	0	34,783	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	96,615	96,615	0	96,615	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 *	421,899	131,398	553,297	0	553,297	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	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	6,467	28.00
29.00	LPN/LVN	0	296,669	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	118,763	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	34,783	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	96,615	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	553,297	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CAREProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2020
To 09/30/2021Worksheet 0-3
Date/Time Prepared:
2/28/2022 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	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	41	0	41	0	41	27.00
28.00	REGISTERED NURSE	1,888	0	1,888	0	1,888	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	756	0	756	0	756	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	221	221	0	221	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	615	615	0	615	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 *	2,685	836	3,521	0	3,521	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	41	27.00
28.00	REGISTERED NURSE	0	1,888	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	756	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	221	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	615	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	3,521	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: 14-0167 Hospice CCN: 14-1616		Period: From 10/01/2020 To 09/30/2021		Worksheet 0-4 Date/Time Prepared: 2/28/2022 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	0	0	0	0	26.00		
27.00	NURSE PRACTITIONER	14	0	14	0	14	27.00		
28.00	REGISTERED NURSE	629	0	629	0	629	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	251	0	251	0	251	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	74	74	0	74	42.00		
42.50	DRUGS CHARGED TO PATIENTS	0	205	205	0	205	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 *	894	279	1,173	0	1,173	100.00		

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

			ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
			6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED		0	0	25.00
26.00	PHYSICIAN SERVICES		0	0	26.00
27.00	NURSE PRACTITIONER		0	14	27.00
28.00	REGISTERED NURSE		0	629	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	251	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	74	42.00
42.50	DRUGS CHARGED TO PATIENTS		0	205	42.50
43.00	OUTPATIENT SERVICES		0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY		0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY		0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)		0	0	46.00
100.00	TOTAL *		0	1,173	100.00

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATIONProvider CCN: 14-0167
Hospice CCN: 14-1616Period:
From 10/01/2020
To 09/30/2021Worksheet 0-5
Date/Time Prepared:
2/28/2022 11:01 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,451	14,451	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	9,176	112,394	121,570	3.00
4.00	ADMINISTRATIVE & GENERAL	241,218	198,923	440,141	4.00
5.00	PLANT OPERATION & MAINTENANCE	14,773	0	14,773	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	63,157	0	63,157	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	4,108	4,108	10.00
11.00	MEDICAL RECORDS	0	13,238	13,238	11.00
12.00	STAFF TRANSPORTATION	4,900	0	4,900	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	80,273	0	80,273	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	553,297	0	553,297	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,521	0	3,521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,173	0	1,173	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	971,488	343,114	1,314,602	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0		1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,451			14,451			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	121,570		0	0	121,570		3.00
4.00	ADMINISTRATIVE & GENERAL	440,141		0	14,451	0	454,592	4.00
5.00	PLANT OPERATION & MAINTENANCE	14,773		0	0	0	14,773	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	63,157		0	0	0	63,157	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,108		0	0	0	4,108	10.00
11.00	MEDICAL RECORDS	13,238		0	0	0	13,238	11.00
12.00	STAFF TRANSPORTATION	4,900		0	0	0	4,900	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	0	0	0	13.00
14.00	PHARMACY	0		0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	80,273		0	0	0	80,273	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	553,297				121,570	674,867	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,521		0	0	0	3,521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,173		0	0	0	1,173	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0		0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0		0	0	0	0	61.00
62.00	FUNDRAISING	0		0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0		0	0	0	0	66.00
67.00	ADVERTISING	0		0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	0	0	0	68.00
69.00	THRIFT STORE	0		0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0	0	0	0	99.00
100.00	TOTAL	1,314,602		0	14,451	121,570	1,314,602	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	454,592						4.00
5.00	PLANT OPERATION & MAINTENANCE	7,809	22,582					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	33,384	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,171	0			0		10.00
11.00	MEDICAL RECORDS	6,997	0			0		11.00
12.00	STAFF TRANSPORTATION	2,590	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	42,431	22,582			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	356,729						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,861	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	620	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	0	0		0	0	0	99.00
100.00	TOTAL	454,592	22,582		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Descriptions		Hospice I				
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION
		9.00	10.00	11.00	12.00	13.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	96,541				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	6,279			10.00
11.00	MEDICAL RECORDS	0		20,235		11.00
12.00	STAFF TRANSPORTATION	0			7,490	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	95,678	6,222	20,054	7,415	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	609	40	128	19	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	254	17	53	56	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	60.00
61.00	VOLUNTEER PROGRAM	0			0	61.00
62.00	FUNDRAISING	0			0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	65.00
66.00	RESIDENTIAL CARE	0			0	66.00
67.00	ADVERTISING	0			0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	68.00
69.00	THRIFT STORE	0			0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	96,541	6,279	20,235	7,490	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 11:01 am

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		145,286			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	143,988		1,304,953	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	916	0	7,094	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	382	0	2,555	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	145,286	0	1,314,602	100.00

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

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,350					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		15,261				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	648,628			3.00
4.00	ADMINISTRATIVE & GENERAL	0	15,261	0	-454,592	860,010	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	14,773	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	63,157	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	4,108	10.00
11.00	MEDICAL RECORDS	0	0	0	0	13,238	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	4,900	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	2,350	0	0	0	80,273	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			648,628	0	674,867	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	3,521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	1,173	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	14,451	121,570		454,592	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.946924	0.187426		0.528589	101.00

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

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	2,350					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		2,350			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		11,415	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	2,350		2,350		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					11,313	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	72	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	30	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)	22,582	0	0	0	96,541	100.00
101.00	UNIT COST MULTIPLIER	9.609362	0.000000	0.000000	0.000000	8.457381	101.00

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

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

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

Worksheet 0-6
Part II
Date/Time Prepared:
2/28/2022 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	11,415				10.00
11.00	MEDICAL RECORDS		11,415			11.00
12.00	STAFF TRANSPORTATION			33,692		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0	0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	11,313	11,313	33,356	0	0 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	72	72	84	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	30	30	252	0	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	6,279	20,235	7,490	0	0 100.00
101.00	UNIT COST MULTIPLIER	0.550066	1.772668	0.222308	0.000000	0.000000 101.00

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

Provider CCN: 14-0167

Period:

Worksheet 0-6

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 11:01 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		11,415			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	11,313			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	72	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	30	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	145,286	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	12.727639	0.000000		101.00

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

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

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

Worksheet 0-7
Date/Time Prepared:
2/28/2022 11:01 am

					Hospice I			
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				
				HCHC	HRHC	HIRC		
				2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00		
1.00	PHYSICAL THERAPY	66.00	0.522899	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00					2.00	
3.00	SPEECH PATHOLOGY	68.00					3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.346234	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.260306	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.242254	0	0	0	7.00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00	
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00	
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00	
11.00	Totals (sum of lines 1-11)						11.00	
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC					
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)		
		5.00	6.00	7.00	8.00	9.00		
	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY						2.00	
3.00	SPEECH PATHOLOGY						3.00	
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00	
6.00	LABORATORY	0	0	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00	
9.00	RADIOLOGY-THERAPEUTIC						9.00	
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00	
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00	

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0167

Period:

Worksheet 0-8

Hospice CCN: 14-1616

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 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)			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)			1,304,953 6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			11,313 7.00
8.00	Total average cost per diem (line 6 divided by line 7)			115.35 8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	10,859	33	9.00
10.00	Program cost (line 8 times line 9)	1,252,586	3,807	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)			7,094 11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			72 12.00
13.00	Total average cost per diem (line 11 divided by line 12)			98.53 13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	69	0	14.00
15.00	Program cost (line 13 times line 14)	6,799	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)			2,555 16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			30 17.00
18.00	Total average cost per diem (line 16 divided by line 17)			85.17 18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	30	0	19.00
20.00	Program cost (line 18 times line 19)	2,555	0	20.00
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,314,602 21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			11,415 22.00
23.00	Average cost per diem (line 21 divided by line 22)			115.16 23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 2/28/2022 11:01 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		138,852	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,068	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)		3.94	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)		144,920	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3424

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 11:01 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	253,382	0	253,382	-623	252,759
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	161,643	0	161,643	-99	161,544
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	48,218	0	48,218	0	48,218
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	463,243	0	463,243	-722	462,521
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	14,019	14,019	0	14,019
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	14,019	14,019	0	14,019
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	463,243	14,019	477,262	-722	476,540
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	722	722
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	722	722
FACILITY OVERHEAD						
29.00	Facility Costs	0	28,992	28,992	0	28,992
30.00	Administrative Costs	73,039	75,484	148,523	0	148,523
31.00	Total Facility Overhead (sum of lines 29 and 30)	73,039	104,476	177,515	0	177,515
32.00	Total facility costs (sum of lines 22, 28 and 31)	536,282	118,495	654,777	0	654,777

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3424

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-36,159	216,600	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	161,544	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	48,218	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-36,159	426,362	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	14,019	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,019	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-36,159	440,381	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	722	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	722	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	28,992	29.00
30.00	Administrative Costs	-34,619	113,904	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-34,619	142,896	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-70,778	583,999	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3425

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	87,435	0	87,435	0	87,435
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	120,858	0	120,858	-197	120,661
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	208,293	0	208,293	-197	208,096
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	11,709	11,709	0	11,709
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	11,709	11,709	0	11,709
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	208,293	11,709	220,002	-197	219,805
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	197	197
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	197	197
FACILITY OVERHEAD						
29.00	Facility Costs	0	9,093	9,093	0	9,093
30.00	Administrative Costs	61,543	53,476	115,019	0	115,019
31.00	Total Facility Overhead (sum of lines 29 and 30)	61,543	62,569	124,112	0	124,112
32.00	Total facility costs (sum of lines 22, 28 and 31)	269,836	74,278	344,114	0	344,114

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-3425

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	87,435		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	218,730	339,391		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	218,730	426,826		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	11,709		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,709		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	218,730	438,535		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	197		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	197		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	9,093		29.00
30.00	Administrative Costs	-37,552	77,467		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-37,552	86,560		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	181,178	525,292		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 15-3979

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 11:01 am

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	350,968	0	350,968	-605	350,363
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	190,135	0	190,135	-90	190,045
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	0	0	0	0	0
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	541,103	0	541,103	-695	540,408
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	17,265	17,265	0	17,265
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	17,265	17,265	0	17,265
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	541,103	17,265	558,368	-695	557,673
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	694	694
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	694	694
FACILITY OVERHEAD					
29.00 Facility Costs	0	40,944	40,944	0	40,944
30.00 Administrative Costs	159,856	143,520	303,376	0	303,376
31.00 Total Facility Overhead (sum of lines 29 and 30)	159,856	184,464	344,320	0	344,320
32.00 Total facility costs (sum of lines 22, 28 and 31)	700,959	201,729	902,688	-1	902,687

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 15-3979

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC III	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	350,363		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-45,079	144,966		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-45,079	495,329		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	17,265		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,265		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-45,079	512,594		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	694		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	694		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	40,944		29.00
30.00	Administrative Costs	-73,381	229,995		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-73,381	270,939		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-118,460	784,227		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-8551

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 11:01 am

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	613,724	0	613,724	-3,184	610,540	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	61,884	0	61,884	0	61,884	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	143,216	0	143,216	0	143,216	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	818,824	0	818,824	-3,184	815,640	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	18,550	18,550	0	18,550	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,550	18,550	0	18,550	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	818,824	18,550	837,374	-3,184	834,190	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	3,184	3,184	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	3,184	3,184	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	93,020	1,969,273	2,062,293	0	2,062,293	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	93,020	1,969,273	2,062,293	0	2,062,293	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	911,844	1,987,823	2,899,667	0	2,899,667	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0167

Period:

Worksheet M-1

Component CCN: 14-8551

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-137,493	473,047	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	61,884	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	143,216	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-137,493	678,147	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	18,550	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,550	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-137,493	696,697	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	3,184	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,184	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-178,886	1,883,407	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-178,886	1,883,407	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-316,379	2,583,288	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-3424

From 10/01/2020

To 09/30/2021

Date/Time Prepared:

2/28/2022 11:01 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.67	2,024	2,688	1,801		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.57	1,624	2,100	1,197		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.24	3,648		2,998	3,648	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.24	3,648			3,648	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)					440,381	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					722	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					441,103	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998363	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					142,896	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					218,942	15.00
16.00	Total overhead (sum of lines 14 and 15)					361,838	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					361,838	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					361,246	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					801,627	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-3425

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.72	1,143	2,310	1,663		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.46	1,226	1,449	667		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.18	2,369		2,330	2,369	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.18	2,369			2,369	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)					438,535	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					197	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					438,732	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999551	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					86,560	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					258,981	15.00
16.00	Total overhead (sum of lines 14 and 15)					345,541	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					345,541	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					345,386	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					783,921	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 15-3979

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.01	2,314	4,200	4,242		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.26	2,110	2,100	546		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.27	4,424		4,788	4,788	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.27	4,424			4,788	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)					512,594	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					694	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					513,288	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998648	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					270,939	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					368,599	15.00
16.00	Total overhead (sum of lines 14 and 15)					639,538	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					639,538	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					638,673	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,151,267	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0167

Period:

Worksheet M-2

Component CCN: 14-8551

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 11:01 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.78	19,770	4,200	3,276		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.11	2,929	2,100	231		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.89	22,699		3,507	22,699	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)	0.89	22,699			22,699	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)					696,697	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,184	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					699,881	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995451	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,883,407	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					588,423	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,471,830	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,471,830	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,460,586	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,157,283	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167 Component CCN: 14-3424	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/28/2022 11:01 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			801,627	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			13,170	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			788,457	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,648	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,648	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			216.13	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	245.32	8.00
9.00	Rate for Program covered visits (see instructions)	216.13	216.13	216.13	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	366	362	708	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	79,104	78,239	153,020	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	310,363		16.00
16.01	Total program charges (see instructions)(from contractor's records)		210,060		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,133		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		20,882		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.)		210,322		16.04
16.05	Total program cost (see instructions)	0	231,204		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,579		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,870		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		231,204		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,088		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		237,292		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)		237,292		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		183,404		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)		53,888		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3		
		Component CCN: 14-3425		Date/Time Prepared: 2/28/2022 11:01 am		
		Title XVIII	RHC II	Cost		
				1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			783,921	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			14,485	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			769,436	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,369	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)			2,369	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			324.79	7.00	
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	163.17	8.00
9.00	Rate for Program covered visits (see instructions)		324.79	324.79	163.17	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		204	232	466	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		66,257	75,351	76,037	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	217,645		16.00
16.01	Total program charges (see instructions)(from contractor's records)			109,988		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			3,759		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			7,438		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.)			154,750		16.04
16.05	Total program cost (see instructions)		0	162,188		16.05
17.00	Primary payer amounts			297		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			16,769		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			17,892		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			161,891		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			8,554		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			170,445		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)			170,445		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			75,251		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)			95,194		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0		30.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3		
		Component CCN: 15-3979		Date/Time Prepared: 2/28/2022 11:01 am		
		Title XVIII	RHC III	Cost		
				1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,151,267	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			23,164	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,128,103	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,788	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)			4,788	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			235.61	7.00	
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	286.23	8.00
9.00	Rate for Program covered visits (see instructions)		235.61	235.61	235.61	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		689	626	1,289	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		162,335	147,492	303,701	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	613,528		16.00
16.01	Total program charges (see instructions)(from contractor's records)			397,741		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			9,104		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			14,043		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.)			445,995		16.04
16.05	Total program cost (see instructions)		0	460,038		16.05
17.00	Primary payer amounts			0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			41,991		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			69,329		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			460,038		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			11,628		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			471,666		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)			471,666		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			307,431		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)			164,235		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0		30.00

Health Financial Systems		IROQUOIS MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0167	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3		
		Component CCN: 14-8551		Date/Time Prepared: 2/28/2022 11:01 am		
		Title XVIII	RHC IV	Cost		
				1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,157,283	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			68,888	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,088,395	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,699	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)			22,699	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			136.06	7.00	
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)		86.31	87.52	164.43	8.00
9.00	Rate for Program covered visits (see instructions)		136.06	136.06	136.06	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		2,825	3,416	8,216	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		384,370	464,781	1,117,869	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	1,967,020		16.00
16.01	Total program charges (see instructions)(from contractor's records)			2,383,575		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			118,760		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			98,005		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,471,905		16.04
16.05	Total program cost (see instructions)		0	1,569,910		16.05
17.00	Primary payer amounts			0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			29,134		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			447,136		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,569,910		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			40,957		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,610,867		22.00
23.00	Allowable bad debts (see instructions)			0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0		25.50
25.99	Demonstration payment adjustment amount before sequestration			0		25.99
26.00	Net reimbursable amount (see instructions)			1,610,867		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			1,856,050		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)			-245,183		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: 14-0167

Period:

Worksheet M-4

Component CCN: 14-3424

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 11:01 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	426,362	426,362	426,362	426,362	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000156	0.002645	0.000415	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	67	1,128	177	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	651	5,212	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	718	6,340	177	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	440,381	440,381	440,381	440,381	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	361,246	361,246	361,246	361,246	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001630	0.014397	0.000402	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	589	5,201	145	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,307	11,541	322	0	10.00
11.00	Total number of injections/infusions (from your records)	6	102	16	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	217.83	113.15	20.13	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	44	1	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)	1,089	4,979	20	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)		13,170			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)		6,088			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0167

Period:

Worksheet M-4

Component CCN: 14-3425

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

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		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	426,826	426,826	426,826	426,826	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000623	0.004095	0.000223	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	266	1,748	95	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,855	4,139	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,121	5,887	95	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	438,535	438,535	438,535	438,535	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	345,386	345,386	345,386	345,386	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004837	0.013424	0.000217	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,671	4,636	75	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,792	10,523	170	0	10.00
11.00	Total number of injections/infusions (from your records)	14	92	5	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	270.86	114.38	34.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	44	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)	3,521	5,033	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)		14,485			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)		8,554			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0167

Period:

Worksheet M-4

Component CCN: 15-3979

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

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		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	495,329	495,329	495,329	495,329	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000361	0.001828	0.000181	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	179	905	90	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,966	4,174	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,145	5,079	90	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	512,594	512,594	512,594	512,594	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	638,673	638,673	638,673	638,673	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010037	0.009908	0.000176	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,410	6,328	112	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11,555	11,407	202	0	10.00
11.00	Total number of injections/infusions (from your records)	16	81	8	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	722.19	140.83	25.25	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	8	41	3	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)	5,778	5,774	76	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)		23,164			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)		11,628			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0167

Period:

Worksheet M-4

Component CCN: 14-8551

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

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		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	678,147	678,147	678,147	678,147	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000452	0.001957	0.000368	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	307	1,327	250	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,237	6,080	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,544	7,407	250	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	696,697	696,697	696,697	696,697	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,460,586	2,460,586	2,460,586	2,460,586	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010828	0.010632	0.000359	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	26,643	26,161	883	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	34,187	33,568	1,133	0	10.00
11.00	Total number of injections/infusions (from your records)	27	117	22	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	1,266.19	286.91	51.50	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	19	58	5	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)	24,058	16,641	258	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)		68,888			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)		40,957			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-3424	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 11:01 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		154,969	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		06/30/2021	28,435	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)		28,435	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		183,404	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		53,888	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		237,292	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-3425	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 11:01 am	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		103,887	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		06/30/2021	28,636	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)		-28,636	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		75,251	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		95,194	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		170,445	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 15-3979	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 11:01 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		349,286	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		06/30/2021	41,855		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)		-41,855		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		307,431		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		164,235		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		471,666		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0167 Component CCN: 14-8551	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 11:01 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1,874,127	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			06/30/2021	18,077	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)			-18,077	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			1,856,050	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			245,183	6.02
7.00	Total Medicare program liability (see instructions)			1,610,867	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00