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: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/15/2021 3:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/15/2021 Time: 3:43 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (14-1312) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 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.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) LORI GUTIERREZ
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-18,281	-117,570	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	-23,509	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-41,790	-117,570	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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	2.00

		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	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2020	04/30/2021	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	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.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 9/15/2021 3:43 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural St	Date of Geogra	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 9/15/2021 3:43 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/15/2021 3:43 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	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	Y	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 9/15/2021 3:43 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	401,700	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.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	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	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 9/15/2021 3:43 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/21/2021	Y	06/21/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 9/15/2021 3:43 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer	CLIFTONLARSONALLEN, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 9/15/2021 3:43 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 9/15/2021 3:43 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	13	4,745	27,288.00	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)		13	4,745	27,288.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		17	6,205	27,288.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		17				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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	547	25	1,047			1.00
2.00	HMO and other (see instructions)	169	85				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	90	0	90			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)	637	25	1,137			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	637	25	1,137	0.00	294.13	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	294.13	27.00
28.00	Observation Bed Days		0	524			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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	176	8	352	1.00
2.00	HMO and other (see instructions)			45	25		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	176	8	352	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet S-10 | Date/Time Prepared: 9/15/2021 3:43 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.434510	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,327,203	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	10,332,368	6.00
7.00	Medicaid cost (line 1 times line 6)	4,489,517	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)	1,162,314	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)	1,162,314	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)	955,223	284,509	1,239,732	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	415,054	284,509	699,563	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	493	493	22.00
23.00	Cost of charity care (line 21 minus line 22)	415,054	284,016	699,070	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)	1,790,599	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	604,250	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	929,615	27.01
28.00	Non-Medicare bad debt expense (see instructions)	860,984	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	699,471	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,398,541	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,560,855	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		1,124,150	1,124,150	642,150	1,766,300	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,260,037	1,260,037	-390,456	869,581	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	194,925	4,989,030	5,183,955	0	5,183,955	4.00
5.01	00570	ADMITTING	418,512	28,792	447,304	139,639	586,943	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	537,275	334,806	872,081	0	872,081	5.02
5.03	00590	OTHER ADMIN & GENERAL	1,686,309	2,955,559	4,641,868	-7,434	4,634,434	5.03
7.00	00700	OPERATION OF PLANT	356,551	1,062,017	1,418,568	0	1,418,568	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	76,188	76,188	8.00
9.00	00900	HOUSEKEEPING	452,562	130,418	582,980	-70,574	512,406	9.00
10.00	01000	DIETARY	340,804	347,295	688,099	-540,343	147,756	10.00
11.00	01100	CAFETERIA	0	0	0	540,343	540,343	11.00
13.00	01300	NURSING ADMINISTRATION	217,855	40,200	258,055	0	258,055	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,051	29,814	198,865	-5,614	193,251	14.00
15.00	01500	PHARMACY	250,834	1,599,346	1,850,180	-1,438,281	411,899	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	523,515	100,601	624,116	0	624,116	16.00
17.00	01700	SOCIAL SERVICE	276,574	27,471	304,045	0	304,045	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,842,473	664,915	2,507,388	0	2,507,388	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	815,299	638,208	1,453,507	0	1,453,507	50.00
53.00	05300	ANESTHESIOLOGY	0	283,635	283,635	0	283,635	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	758,904	1,121,651	1,880,555	-46,532	1,834,023	54.00
60.00	06000	LABORATORY	969,217	1,640,436	2,609,653	-9,567	2,600,086	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	57,078	57,078	9,567	66,645	62.00
64.00	06400	INTRAVENOUS THERAPY	236,147	22,532	258,679	0	258,679	64.00
65.00	06500	RESPIRATORY THERAPY	207,219	640,855	848,074	-66,859	781,215	65.00
66.00	06600	PHYSICAL THERAPY	459,187	32,741	491,928	-89,770	402,158	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	89,770	89,770	67.00
69.00	06900	ELECTROCARDIOLOGY	0	24,775	24,775	2,315	27,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,689	13,689	0	13,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,983	68,983	0	68,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,484,813	1,484,813	73.00
76.00	03950	DIABETIC SERVICES	26,855	898	27,753	0	27,753	76.00
76.97	07697	CARDIAC REHABILITATION	58,153	27,852	86,005	68,019	154,024	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,537,417	1,175,399	2,712,816	-2,315	2,710,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		182,509	182,509	-182,509	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,335,638	20,625,692	32,961,330	202,550	33,163,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	295,591	121,313	416,904	0	416,904	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	188,137	9,993	198,130	-198,130	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,849,390	277,361	2,126,751	-4,420	2,122,331	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,668,756	21,034,359	35,703,115	0	35,703,115	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-182,509	1,583,791		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,355	868,226		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-36,637	5,147,318		4.00
5.01	00570	ADMITTING	0	586,943		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	872,081		5.02
5.03	00590	OTHER ADMIN & GENERAL	-1,196,290	3,438,144		5.03
7.00	00700	OPERATION OF PLANT	-638	1,417,930		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,188		8.00
9.00	00900	HOUSEKEEPING	0	512,406		9.00
10.00	01000	DIETARY	0	147,756		10.00
11.00	01100	CAFETERIA	-93,029	447,314		11.00
13.00	01300	NURSING ADMINISTRATION	-985	257,070		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	193,251		14.00
15.00	01500	PHARMACY	-10,889	401,010		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,056	620,060		16.00
17.00	01700	SOCIAL SERVICE	0	304,045		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-492,500	2,014,888		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-18,000	1,435,507		50.00
53.00	05300	ANESTHESIOLOGY	-279,008	4,627		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,834,023		54.00
60.00	06000	LABORATORY	0	2,600,086		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	66,645		62.00
64.00	06400	INTRAVENOUS THERAPY	-200	258,479		64.00
65.00	06500	RESPIRATORY THERAPY	0	781,215		65.00
66.00	06600	PHYSICAL THERAPY	0	402,158		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	89,770		67.00
69.00	06900	ELECTROCARDIOLOGY	0	27,090		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,689		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,983		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,484,813		73.00
76.00	03950	DIABETIC SERVICES	0	27,753		76.00
76.97	07697	CARDIAC REHABILITATION	0	154,024		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-722,671	1,987,830		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,038,767	30,125,113		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	416,904		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,122,331		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,038,767	32,664,348		200.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-6 | Date/Time Prepared: 9/15/2021 3:43 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	69,185		1.00
	0		0	69,185		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	267,623	272,720		1.00
	0		267,623	272,720		
	C - RECEPTIONIST-NURSING					
1.00	ADMITTING	5.01	132,596	7,043		1.00
2.00	RESPIRATORY THERAPY	65.00	55,541	2,950		2.00
	0		188,137	9,993		
	D - FITNESS CENTER					
1.00	OTHER ADMIN & GENERAL	5.03	0	57,331		1.00
2.00	CARDIAC REHABILITATION	76.97	0	68,019		2.00
	0		0	125,350		
	E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,509		1.00
	0		0	182,509		
	F - EKGS					
1.00	ELECTROCARDIOLOGY	69.00	2,315	0		1.00
	0		2,315	0		
	G - FIXED EQUIPMENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	411,375		1.00
	0		0	411,375		
	H - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	83,795	5,975		1.00
	0		83,795	5,975		
	I - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	76,188		1.00
2.00		0.00	0	0		2.00
	0		0	76,188		
	J - PHYSICIAN ADMIN COSTS					
1.00	OTHER ADMIN & GENERAL	5.03	4,420	0		1.00
	0		4,420	0		
	K - BLOOD BANK SALARIES					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	9,567	0		1.00
	0		9,567	0		
	L - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,484,813		1.00
2.00		0.00	0	0		2.00
	0		0	1,484,813		
500.00	Grand Total: Increases		555,857	2,638,108		500.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-6 | Date/Time Prepared: 9/15/2021 3:43 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	OTHER ADMIN & GENERAL	5.03	0	69,185	12	1.00
	0		0	69,185		
	B - CAFETERIA					
1.00	DIETARY	10.00	267,623	272,720	0	1.00
	0		267,623	272,720		
	C - RECEPTIONIST-NURSING					
1.00	PHYSICIANS CLINICS	194.02	188,137	9,993	0	1.00
2.00		0.00	0	0	0	2.00
	0		188,137	9,993		
	D - FITNESS CENTER					
1.00	RESPIRATORY THERAPY	65.00	0	125,350	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	125,350		
	E - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	182,509	11	1.00
	0		0	182,509		
	F - EKGS					
1.00	EMERGENCY	91.00	2,315	0	0	1.00
	0		2,315	0		
	G - FIXED EQUIPMENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	411,375	9	1.00
	0		0	411,375		
	H - OCCUPATIONAL THERAPY					
1.00	PHYSICAL THERAPY	66.00	83,795	5,975	0	1.00
	0		83,795	5,975		
	I - LAUNDRY AND LINEN					
1.00	HOUSEKEEPING	9.00	0	70,574	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,614	0	2.00
	0		0	76,188		
	J - PHYSICIAN ADMIN COSTS					
1.00	HEALTH & WELLNESS CENTER	194.03	4,420	0	0	1.00
	0		4,420	0		
	K - BLOOD BANK SALARIES					
1.00	LABORATORY	60.00	9,567	0	0	1.00
	0		9,567	0		
	L - DRUG COSTS					
1.00	PHARMACY	15.00	0	1,438,281	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	46,532	0	2.00
	0		0	1,484,813		
500.00	Grand Total: Decreases		555,857	2,638,108		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,684,161	0	0	0	0	1.00
2.00	Land Improvements	1,463,837	22,420	0	22,420	0	2.00
3.00	Buildings and Fixtures	22,331,507	0	0	0	314,711	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,735,593	679,609	0	679,609	123,190	5.00
6.00	Movable Equipment	9,552,208	1,710,111	0	1,710,111	427,067	6.00
7.00	HIT designated Assets	3,464,930	0	0	0	656,905	7.00
8.00	Subtotal (sum of lines 1-7)	44,232,236	2,412,140	0	2,412,140	1,521,873	8.00
9.00	Reconciling Items	125,947	1,352,101	0	1,352,101	1,459,681	9.00
10.00	Total (line 8 minus line 9)	44,106,289	1,060,039	0	1,060,039	62,192	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,684,161	0	1.00
2.00	Land Improvements	1,486,257	0	2.00
3.00	Buildings and Fixtures	22,016,796	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,292,012	0	5.00
6.00	Movable Equipment	10,835,252	0	6.00
7.00	HIT designated Assets	2,808,025	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,122,503	0	8.00
9.00	Reconciling Items	18,367	0	9.00
10.00	Total (line 8 minus line 9)	45,104,136	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 9/15/2021 3:43 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,107,049	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,260,037	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,367,086	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	17,101	1,124,150	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,260,037	2.00
3.00	Total (sum of lines 1-2)	17,101	2,384,187	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 9/15/2021 3:43 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	31,479,226	0	31,479,226	0.697639	48,266	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,643,277	0	13,643,277	0.302361	20,919	2.00
3.00	Total (sum of lines 1-2)	45,122,503	0	45,122,503	1.000000	69,185	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	48,266	1,518,424	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,919	847,307	0	2.00
3.00	Total (sum of lines 1-2)	0	0	69,185	2,365,731	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	0	48,266	0	17,101	1,583,791	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,919	0	0	868,226	2.00
3.00	Total (sum of lines 1-2)	0	69,185	0	17,101	2,452,017	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-8 | Date/Time Prepared: 9/15/2021 3:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-182,509	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-638	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,512,379			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-93,029	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	B	-4,056	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** 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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	EDUCATION CLASS INCOME	B	-985	NURSING ADMINISTRATION	13.00	0	33.00
33.01	CREDENTIALING	B	-9,700	OTHER ADMIN & GENERAL	5.03	0	33.01
33.02	MISCELLANEOUS INCOME	B	-44,400	OTHER ADMIN & GENERAL	5.03	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-8 | Date/Time Prepared: 9/15/2021 3:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	FITNESS CENTER	B	-11,417	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MARKETING EXPENSE	A	-294,192	OTHER ADMIN & GENERAL	5.03	0	33.04
33.05	LOBBYING EXPENSE	A	-13,529	OTHER ADMIN & GENERAL	5.03	0	33.05
33.06	PROPERTY TAX	A	-13,100	OTHER ADMIN & GENERAL	5.03	0	33.06
33.07	ASSESSMENT TAX	A	-799,124	OTHER ADMIN & GENERAL	5.03	0	33.07
33.08	PHYSICIAN BENEFITS	A	-17,350	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.10	TELEPHONE SERVICES	A	-989	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	TELEPHONE SERVICES	A	-3,078	OTHER ADMIN & GENERAL	5.03	0	33.11
33.12	TELEPHONE SERVICES	A	-1,355	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	MARKETING BENEFITS	A	-16,721	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	MISC REVENUE - DEF COMP	B	-1,577	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	340B RETIAL PHARMACY COSTS	A	-10,889	PHARMACY	15.00	0	33.15
33.17	DONATIONS	A	-7,750	OTHER ADMIN & GENERAL	5.03	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,038,767				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 9/15/2021 3:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	492,500	492,500	0	0	0	1.00
2.00	50.00	OPERATING ROOM	18,000	18,000	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	279,008	279,008	0	0	0	3.00
4.00	64.00	INTRAVENOUS THERAPY	200	200	0	0	0	4.00
5.00	91.00	EMERGENCY	900,678	552,863	347,815	0	0	5.00
6.00	91.00	EMERGENCY	169,808	169,808	0	0	0	6.00
7.00	0.00		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			1,860,194	1,512,379	347,815		0	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		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			0	0	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	30.00	ADULTS & PEDIATRICS	0	0	0	492,500		1.00
2.00	50.00	OPERATING ROOM	0	0	0	18,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	279,008		3.00
4.00	64.00	INTRAVENOUS THERAPY	0	0	0	200		4.00
5.00	91.00	EMERGENCY	0	0	0	552,863		5.00
6.00	91.00	EMERGENCY	0	0	0	169,808		6.00
7.00	0.00		0	0	0	0		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	0	0	1,512,379		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/15/2021 3:43 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		35	1.00
2.00	Line 1 multiplied by 15 hours per week		525	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		245	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.80	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,200.00	7,535.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	77.98	67.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.91	33.91	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		93,576	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		510,948	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		604,524	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		604,524	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		604,524	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		8,308	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		8,308	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,421	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		9,729	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		9,729	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2021 3:43 pm

		Respiratory Therapy	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.81	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	604,524	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,729	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	614,253	63.00
64.00	Total cost of outside supplier services (from your records)	502,238	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,308	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,421	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,729	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,421	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,421	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				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	1,583,791	1,583,791				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	868,226		868,226			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,147,318	4,865	349	5,152,532		4.00
5.01	00570	ADMITTING	586,943	9,263	1,694	199,627	797,527	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	872,081	41,184	4,926	194,616	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	3,438,144	360,494	125,219	577,251	0	5.03
7.00	00700	OPERATION OF PLANT	1,417,930	137,884	7,009	129,153	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,188	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	512,406	9,201	3,824	163,931	0	9.00
10.00	01000	DIETARY	147,756	35,102	1,389	26,508	0	10.00
11.00	01100	CAFETERIA	447,314	22,331	0	96,941	0	11.00
13.00	01300	NURSING ADMINISTRATION	257,070	18,011	1,602	78,913	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	193,251	28,693	1,022	61,235	0	14.00
15.00	01500	PHARMACY	401,010	23,578	32,606	90,859	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	620,060	22,081	4,874	189,632	0	16.00
17.00	01700	SOCIAL SERVICE	304,045	2,386	0	100,183	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,014,888	154,382	45,410	667,395	40,573	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,435,507	116,722	199,416	295,324	61,417	50.00
53.00	05300	ANESTHESIOLOGY	4,627	2,495	23,374	0	10,479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,834,023	78,735	311,390	274,896	223,164	54.00
60.00	06000	LABORATORY	2,600,086	28,927	46,121	347,612	165,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	66,645	3,368	762	3,465	1,650	62.00
64.00	06400	INTRAVENOUS THERAPY	258,479	17,310	8,830	85,467	5,837	64.00
65.00	06500	RESPIRATORY THERAPY	781,215	14,783	3,349	95,179	10,693	65.00
66.00	06600	PHYSICAL THERAPY	402,158	39,438	1,313	135,977	23,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,770	5,130	170	30,353	3,058	67.00
69.00	06900	ELECTROCARDIOLOGY	27,090	0	0	839	12,093	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,689	0	0	0	6,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,983	0	0	0	2,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,484,813	0	0	0	145,743	73.00
76.00	03950	DIABETIC SERVICES	27,753	2,058	0	9,728	237	76.00
76.97	07697	CARDIAC REHABILITATION	154,024	50,681	1,194	21,065	2,081	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,987,830	105,884	13,290	501,020	81,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,125,113	1,334,986	839,133	4,377,169	797,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,220	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	416,904	0	830	107,071	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	60,505	8,915	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	2,122,331	181,080	19,348	668,292	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,664,348	1,583,791	868,226	5,152,532	797,527	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,112,807					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	4,501,108	4,501,108			5.03
7.00	00700	OPERATION OF PLANT	0	1,691,976	270,415	1,962,391		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,188	12,177	0	88,365	8.00
9.00	00900	HOUSEKEEPING	0	689,362	110,175	17,527	0	9.00
10.00	01000	DIETARY	0	210,755	33,683	66,872	0	10.00
11.00	01100	CAFETERIA	0	566,586	90,553	42,541	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	355,596	56,832	34,312	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	284,201	45,422	54,662	0	14.00
15.00	01500	PHARMACY	0	548,053	87,591	44,918	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	836,647	133,715	42,066	0	16.00
17.00	01700	SOCIAL SERVICE	0	406,614	64,986	4,545	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,105	2,978,753	476,070	294,105	23,489	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,928	2,193,314	350,540	222,361	14,353	50.00
53.00	05300	ANESTHESIOLOGY	14,491	55,466	8,865	4,753	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,580	3,030,788	484,387	149,993	17,571	54.00
60.00	06000	LABORATORY	228,833	3,417,063	546,121	55,107	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,281	78,171	12,493	6,417	0	62.00
64.00	06400	INTRAVENOUS THERAPY	8,072	383,995	61,371	32,975	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,786	920,005	147,037	28,163	0	65.00
66.00	06600	PHYSICAL THERAPY	32,527	634,936	101,477	75,130	5,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,228	132,709	21,210	9,774	688	67.00
69.00	06900	ELECTROCARDIOLOGY	16,722	56,744	9,069	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,132	29,425	4,703	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,015	75,901	12,131	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,536	1,832,092	292,809	0	0	73.00
76.00	03950	DIABETIC SERVICES	328	40,104	6,410	3,921	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,877	231,922	37,066	96,550	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	113,375	2,803,387	448,043	201,714	26,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,102,816	29,061,861	3,925,351	1,488,406	88,365	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,220	1,154	13,755	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	524,805	83,875	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	9,991	79,411	12,692	115,265	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,991,051	478,036	344,965	0	194.03
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)	1,112,807	32,664,348	4,501,108	1,962,391	88,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	817,064					9.00
10.00	01000	DIETARY	28,094	339,404				10.00
11.00	01100	CAFETERIA	17,872	0	717,552			11.00
13.00	01300	NURSING ADMINISTRATION	14,415	0	8,052	469,207		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,964	0	10,258	0	417,507	14.00
15.00	01500	PHARMACY	18,871	0	10,552	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,672	0	36,324	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,910	0	10,405	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	123,557	277,711	183,643	229,575	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	93,417	24,009	42,942	53,681	0	50.00
53.00	05300	ANESTHESIOLOGY	1,997	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,014	0	59,119	0	0	54.00
60.00	06000	LABORATORY	23,151	0	91,987	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,696	0	919	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	13,853	10,272	10,552	13,189	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,832	0	15,147	3,367	0	65.00
66.00	06600	PHYSICAL THERAPY	31,563	0	24,780	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,106	0	4,890	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	257	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	288,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	129,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	1,647	0	1,287	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	40,562	0	5,221	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	84,743	27,412	135,260	169,395	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	617,936	339,404	651,595	469,207	417,507	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,778	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	48,425	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	144,925	0	65,957	0	0	194.03
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)	817,064	339,404	717,552	469,207	417,507	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part I Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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
15.00	01500	PHARMACY	709,985					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,066,424				16.00
17.00	01700	SOCIAL SERVICE	0	0	488,460			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	190,861	488,460	5,266,224	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,414	0	3,037,031	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	71,081	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,250	58,232	0	3,885,354	0	54.00
60.00	06000	LABORATORY	0	199,379	0	4,332,808	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	100,696	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	234,492	0	760,699	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,519	0	1,130,070	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,844	0	895,021	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,839	0	176,216	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	66,070	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	322,208	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	217,459	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	687,735	0	0	2,812,636	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	53,369	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	411,321	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	311,844	0	4,208,771	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	709,985	1,066,424	488,460	27,747,034	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	27,907	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	608,680	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	255,793	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	4,024,934	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	709,985	1,066,424	488,460	32,664,348	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Total		
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,266,224		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,037,031		50.00
53.00	05300	ANESTHESIOLOGY	71,081		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,885,354		54.00
60.00	06000	LABORATORY	4,332,808		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,696		62.00
64.00	06400	INTRAVENOUS THERAPY	760,699		64.00
65.00	06500	RESPIRATORY THERAPY	1,130,070		65.00
66.00	06600	PHYSICAL THERAPY	895,021		66.00
67.00	06700	OCCUPATIONAL THERAPY	176,216		67.00
69.00	06900	ELECTROCARDIOLOGY	66,070		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	322,208		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	217,459		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,812,636		73.00
76.00	03950	DIABETIC SERVICES	53,369		76.00
76.97	07697	CARDIAC REHABILITATION	411,321		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	4,208,771		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,747,034		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,907		190.00
194.00	07950	OCCUPATIONAL HEALTH	608,680		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	255,793		194.02
194.03	07953	HEALTH & WELLNESS CENTER	4,024,934		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	32,664,348		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part II Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	0	4,865	349	5,214	5,214	4.00
5.01	00570	ADMITTING	0	9,263	1,694	10,957	202	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	41,184	4,926	46,110	197	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	360,494	125,219	485,713	585	5.03
7.00	00700	OPERATION OF PLANT	0	137,884	7,009	144,893	131	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	9,201	3,824	13,025	166	9.00
10.00	01000	DIETARY	0	35,102	1,389	36,491	27	10.00
11.00	01100	CAFETERIA	0	22,331	0	22,331	98	11.00
13.00	01300	NURSING ADMINISTRATION	0	18,011	1,602	19,613	80	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,693	1,022	29,715	62	14.00
15.00	01500	PHARMACY	0	23,578	32,606	56,184	92	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,081	4,874	26,955	192	16.00
17.00	01700	SOCIAL SERVICE	0	2,386	0	2,386	102	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	154,382	45,410	199,792	676	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	116,722	199,416	316,138	299	50.00
53.00	05300	ANESTHESIOLOGY	0	2,495	23,374	25,869	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,735	311,390	390,125	279	54.00
60.00	06000	LABORATORY	0	28,927	46,121	75,048	352	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,368	762	4,130	4	62.00
64.00	06400	INTRAVENOUS THERAPY	0	17,310	8,830	26,140	87	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,783	3,349	18,132	96	65.00
66.00	06600	PHYSICAL THERAPY	0	39,438	1,313	40,751	138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,130	170	5,300	31	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1	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
76.00	03950	DIABETIC SERVICES	0	2,058	0	2,058	10	76.00
76.97	07697	CARDIAC REHABILITATION	0	50,681	1,194	51,875	21	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	105,884	13,290	119,174	508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,334,986	839,133	2,174,119	4,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,220	0	7,220	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	830	830	108	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	60,505	8,915	69,420	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	181,080	19,348	200,428	670	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,583,791	868,226	2,452,017	5,214	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part II Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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	11,159					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	46,307				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	486,298			5.03
7.00	00700	OPERATION OF PLANT	0	0	29,215	174,239		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,316	0	1,316	8.00
9.00	00900	HOUSEKEEPING	0	0	11,903	1,556	0	9.00
10.00	01000	DIETARY	0	0	3,639	5,937	0	10.00
11.00	01100	CAFETERIA	0	0	9,783	3,777	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	6,140	3,047	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,907	4,853	0	14.00
15.00	01500	PHARMACY	0	0	9,463	3,988	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	14,446	3,735	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	7,021	404	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	569	2,336	51,434	26,113	350	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	861	3,536	37,872	19,743	214	50.00
53.00	05300	ANESTHESIOLOGY	147	603	958	422	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,109	12,824	52,333	13,318	262	54.00
60.00	06000	LABORATORY	2,319	9,527	59,007	4,893	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23	95	1,350	570	0	62.00
64.00	06400	INTRAVENOUS THERAPY	82	336	6,630	2,928	0	64.00
65.00	06500	RESPIRATORY THERAPY	150	616	15,886	2,501	0	65.00
66.00	06600	PHYSICAL THERAPY	330	1,354	10,963	6,671	79	66.00
67.00	06700	OCCUPATIONAL THERAPY	43	176	2,291	868	10	67.00
69.00	06900	ELECTROCARDIOLOGY	169	696	980	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93	380	508	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41	167	1,311	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,042	8,391	31,635	0	0	73.00
76.00	03950	DIABETIC SERVICES	3	14	692	348	0	76.00
76.97	07697	CARDIAC REHABILITATION	29	120	4,005	8,573	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,149	4,720	48,406	17,910	401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,159	45,891	424,094	132,155	1,316	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	125	1,221	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	9,062	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	416	1,371	10,234	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	51,646	30,629	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,159	46,307	486,298	174,239	1,316	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	26,650					9.00
10.00	01000	DIETARY	916	47,010				10.00
11.00	01100	CAFETERIA	583	0	36,572			11.00
13.00	01300	NURSING ADMINISTRATION	470	0	410	29,760		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	749	0	523	0	40,809	14.00
15.00	01500	PHARMACY	615	0	538	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	576	0	1,851	0	0	16.00
17.00	01700	SOCIAL SERVICE	62	0	530	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,030	38,465	9,360	14,560	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,047	3,325	2,189	3,405	0	50.00
53.00	05300	ANESTHESIOLOGY	65	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,055	0	3,013	0	0	54.00
60.00	06000	LABORATORY	755	0	4,688	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88	0	47	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	452	1,423	538	837	0	64.00
65.00	06500	RESPIRATORY THERAPY	386	0	772	214	0	65.00
66.00	06600	PHYSICAL THERAPY	1,029	0	1,263	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	134	0	249	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	13	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	28,158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	54	0	66	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,323	0	266	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,764	3,797	6,894	10,744	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,153	47,010	33,210	29,760	40,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	188	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	1,579	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	4,730	0	3,362	0	0	194.03
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)	26,650	47,010	36,572	29,760	40,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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
15.00	01500	PHARMACY	70,880					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,755				16.00
17.00	01700	SOCIAL SERVICE	0	0	10,505			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,547	10,505	366,737	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,899	0	392,528	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,064	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,221	2,608	0	482,147	0	54.00
60.00	06000	LABORATORY	0	8,928	0	165,517	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,307	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,501	0	49,954	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	202	0	38,955	0	65.00
66.00	06600	PHYSICAL THERAPY	0	978	0	63,556	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	127	0	9,229	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,859	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	29,139	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,170	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,659	0	0	110,727	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	3,245	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	66,212	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	13,965	0	230,432	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,880	47,755	10,505	2,058,778	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,754	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	10,000	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	83,020	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	291,465	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	70,880	47,755	10,505	2,452,017	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Total		
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	366,737		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	392,528		50.00
53.00	05300	ANESTHESIOLOGY	28,064		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,147		54.00
60.00	06000	LABORATORY	165,517		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,307		62.00
64.00	06400	INTRAVENOUS THERAPY	49,954		64.00
65.00	06500	RESPIRATORY THERAPY	38,955		65.00
66.00	06600	PHYSICAL THERAPY	63,556		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,229		67.00
69.00	06900	ELECTROCARDIOLOGY	1,859		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,139		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,727		73.00
76.00	03950	DIABETIC SERVICES	3,245		76.00
76.97	07697	CARDIAC REHABILITATION	66,212		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	230,432		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,058,778		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,754		190.00
194.00	07950	OCCUPATIONAL HEALTH	10,000		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	83,020		194.02
194.03	07953	HEALTH & WELLNESS CENTER	291,465		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,452,017		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	101,563					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		847,307				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312	341	14,224,574			4.00
5.01	00570	ADMITTING	594	1,653	551,108	63,858,184		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,641	4,807	537,275	0	64,436,682	5.02
5.03	00590	OTHER ADMIN & GENERAL	23,117	122,202	1,593,612	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	6,840	356,551	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	3,732	452,562	0	0	9.00
10.00	01000	DIETARY	2,251	1,356	73,181	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	267,623	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,155	1,563	217,855	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,840	997	169,051	0	0	14.00
15.00	01500	PHARMACY	1,512	31,820	250,834	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	4,757	523,515	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	276,574	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,900	44,316	1,842,473	3,248,721	3,248,721	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,485	194,611	815,299	4,917,666	4,917,666	50.00
53.00	05300	ANESTHESIOLOGY	160	22,811	0	839,083	839,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	303,888	758,904	17,868,780	17,868,780	54.00
60.00	06000	LABORATORY	1,855	45,010	959,650	13,250,344	13,250,344	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	216	744	9,567	132,100	132,100	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	8,617	235,947	467,392	467,392	64.00
65.00	06500	RESPIRATORY THERAPY	948	3,268	262,760	856,175	856,175	65.00
66.00	06600	PHYSICAL THERAPY	2,529	1,281	375,392	1,883,464	1,883,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	329	166	83,795	244,818	244,818	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,315	968,253	968,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	528,797	528,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	232,482	232,482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,669,695	11,669,695	73.00
76.00	03950	DIABETIC SERVICES	132	0	26,855	18,995	18,995	76.00
76.97	07697	CARDIAC REHABILITATION	3,250	1,165	58,153	166,594	166,594	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,790	12,970	1,383,162	6,564,825	6,564,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,608	818,915	12,084,013	63,858,184	63,858,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	810	295,591	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,880	8,700	0	0	578,498	194.02
194.03	07953	HEALTH & WELLNESS CENTER	11,612	18,882	1,844,970	0	0	194.03
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)	1,583,791	868,226	5,152,532	797,527	1,112,807	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.594173	1.024689	0.362228	0.012489	0.017270	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,214	11,159	46,307	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000367	0.000175	0.000719	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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-4,501,108	28,163,240				5.03
7.00	00700	OPERATION OF PLANT	0	1,691,976	66,057			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,188	0	95,947		8.00
9.00	00900	HOUSEKEEPING	0	689,362	590	0	65,467	9.00
10.00	01000	DIETARY	0	210,755	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	566,586	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	355,596	1,155	0	1,155	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	284,201	1,840	0	1,840	14.00
15.00	01500	PHARMACY	0	548,053	1,512	0	1,512	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	836,647	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	406,614	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,978,753	9,900	25,504	9,900	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,193,314	7,485	15,584	7,485	50.00
53.00	05300	ANESTHESIOLOGY	0	55,466	160	0	160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,030,788	5,049	19,079	5,049	54.00
60.00	06000	LABORATORY	0	3,417,063	1,855	0	1,855	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	78,171	216	0	216	62.00
64.00	06400	INTRAVENOUS THERAPY	0	383,995	1,110	0	1,110	64.00
65.00	06500	RESPIRATORY THERAPY	0	920,005	948	0	948	65.00
66.00	06600	PHYSICAL THERAPY	0	634,936	2,529	5,745	2,529	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	132,709	329	747	329	67.00
69.00	06900	ELECTROCARDIOLOGY	0	56,744	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,425	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	75,901	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,832,092	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	40,104	132	0	132	76.00
76.97	07697	CARDIAC REHABILITATION	0	231,922	3,250	0	3,250	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,803,387	6,790	29,288	6,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,501,108	24,560,753	50,102	95,947	49,512	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,220	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	524,805	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	79,411	3,880	0	3,880	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,991,051	11,612	0	11,612	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		4,501,108	1,962,391	88,365	817,064	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.159822	29.707540	0.920977	12.480547	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		486,298	174,239	1,316	26,650	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.017267	2.637707	0.013716	0.407075	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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	5,386					10.00
11.00	01100	CAFETERIA	0	19,517				11.00
13.00	01300	NURSING ADMINISTRATION	0	219	212,346			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	279	0	100		14.00
15.00	01500	PHARMACY	0	287	0	0	1,484,813	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	988	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	283	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,407	4,995	103,897	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	381	1,168	24,294	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,608	0	0	46,532	54.00
60.00	06000	LABORATORY	0	2,502	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	163	287	5,969	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	412	1,524	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	674	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	133	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	7	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	69	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,438,281	73.00
76.00	03950	DIABETIC SERVICES	0	35	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	142	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	435	3,679	76,662	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,386	17,723	212,346	100	1,484,813	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,794	0	0	0	194.03
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)	339,404	717,552	469,207	417,507	709,985	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	63.015967	36.765486	2.209634	4,175.070000	0.478165	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,010	36,572	29,760	40,809	70,880	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.728184	1.873854	0.140149	408.090000	0.047737	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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/15/2021 3:43 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			16.00	17.00		
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,025			16.00
17.00	01700	SOCIAL SERVICE	0	1,047		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	16,470	1,047		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,660	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,025	0		54.00
60.00	06000	LABORATORY	17,205	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	20,235	0		64.00
65.00	06500	RESPIRATORY THERAPY	390	0		65.00
66.00	06600	PHYSICAL THERAPY	1,885	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	245	0		67.00
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	0		73.00
76.00	03950	DIABETIC SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	26,910	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,025	1,047		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0		194.03
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)	1,066,424	488,460		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.588416	466.532951		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,755	10,505		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.518935	10.033429		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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,266,224		5,266,224	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,037,031		3,037,031	0	0	50.00
53.00	05300	ANESTHESIOLOGY	71,081		71,081	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,885,354		3,885,354	0	0	54.00
60.00	06000	LABORATORY	4,332,808		4,332,808	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,696		100,696	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	760,699		760,699	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,130,070	0	1,130,070	0	0	65.00
66.00	06600	PHYSICAL THERAPY	895,021	0	895,021	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,216	0	176,216	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	66,070		66,070	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	322,208		322,208	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	217,459		217,459	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,812,636		2,812,636	0	0	73.00
76.00	03950	DIABETIC SERVICES	53,369		53,369	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	411,321		411,321	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	4,208,771		4,208,771	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,661,347		1,661,347		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,408,381	0	29,408,381	0	0	200.00
201.00		Less Observation Beds	1,661,347		1,661,347		0	201.00
202.00		Total (see instructions)	27,747,034	0	27,747,034	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,537,250		1,537,250			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	571,701	4,345,965	4,917,666	0.617576	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	87,377	751,706	839,083	0.084713	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	334,055	17,534,725	17,868,780	0.217438	0.000000	54.00
60.00	06000	LABORATORY	839,802	12,410,542	13,250,344	0.326996	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,320	93,780	132,100	0.762271	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	467,392	467,392	1.627540	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	190,965	665,210	856,175	1.319905	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	102,802	1,780,662	1,883,464	0.475199	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,293	222,525	244,818	0.719784	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	13,026	955,227	968,253	0.068236	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	324,527	204,270	528,797	0.609323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	85,356	147,126	232,482	0.935380	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718,699	9,950,996	11,669,695	0.241021	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	18,995	18,995	2.809634	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	166,594	166,594	2.469002	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	6,564,825	6,564,825	0.641109	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,711,471	1,711,471	0.970713	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,866,173	57,992,011	63,858,184			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,866,173	57,992,011	63,858,184			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet C Part I Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	DIABETIC SERVICES	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D Part II Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		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	392,528	4,917,666	0.079820	243,325	19,422	50.00
53.00	05300	ANESTHESIOLOGY	28,064	839,083	0.033446	40,260	1,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,147	17,868,780	0.026983	238,497	6,435	54.00
60.00	06000	LABORATORY	165,517	13,250,344	0.012492	449,130	5,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,307	132,100	0.047744	19,900	950	62.00
64.00	06400	INTRAVENOUS THERAPY	49,954	467,392	0.106878	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	38,955	856,175	0.045499	86,366	3,930	65.00
66.00	06600	PHYSICAL THERAPY	63,556	1,883,464	0.033744	47,249	1,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,229	244,818	0.037697	9,173	346	67.00
69.00	06900	ELECTROCARDIOLOGY	1,859	968,253	0.001920	12,358	24	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,139	528,797	0.055104	153,748	8,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,170	232,482	0.060951	51,555	3,142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,727	11,669,695	0.009488	728,562	6,913	73.00
76.00	03950	DIABETIC SERVICES	3,245	18,995	0.170834	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	66,212	166,594	0.397445	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	230,432	6,564,825	0.035101	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,695	1,711,471	0.067600	0	0	92.00
200.00		Total (lines 50 through 199)	1,807,736	62,320,934		2,080,123	58,186	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D Part IV | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D Part IV Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,917,666	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	839,083	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,868,780	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,250,344	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	132,100	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	467,392	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	856,175	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,883,464	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	244,818	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	968,253	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	528,797	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	232,482	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,669,695	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	18,995	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	166,594	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,564,825	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,711,471	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	62,320,934		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D Part IV | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		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	243,325	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	40,260	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	238,497	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	449,130	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	19,900	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	86,366	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	47,249	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,173	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,358	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	153,748	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	51,555	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	728,562	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,080,123	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D Part V Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.617576	0	1,369,995	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.084713	0	236,676	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217438	0	5,469,728	0	0	54.00
60.00	06000	LABORATORY	0.326996	0	3,723,538	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.762271	0	77,129	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.627540	0	170,554	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.319905	0	241,542	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.475199	0	481,253	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.719784	0	58,306	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.068236	0	352,370	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.609323	0	96,152	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.935380	0	61,445	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241021	0	4,956,402	0	0	73.00
76.00	03950	DIABETIC SERVICES	2.809634	0	7,905	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2.469002	0	80,402	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.641109	0	1,838,093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970713	0	607,301	3,280	0	92.00
200.00		Subtotal (see instructions)		0	19,828,791	3,280	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	19,828,791	3,280	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D Part V Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	846,076	0	50.00
53.00	05300	ANESTHESIOLOGY	20,050	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,189,327	0	54.00
60.00	06000	LABORATORY	1,217,582	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	58,793	0	62.00
64.00	06400	INTRAVENOUS THERAPY	277,583	0	64.00
65.00	06500	RESPIRATORY THERAPY	318,812	0	65.00
66.00	06600	PHYSICAL THERAPY	228,691	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,968	0	67.00
69.00	06900	ELECTROCARDIOLOGY	24,044	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,588	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,474	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,194,597	0	73.00
76.00	03950	DIABETIC SERVICES	22,210	0	76.00
76.97	07697	CARDIAC REHABILITATION	198,513	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	1,178,418	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	589,515	3,184	92.00
200.00		Subtotal (see instructions)	7,522,241	3,184	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	7,522,241	3,184	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

	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)	1,661	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,571	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)	1,047	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	80	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)	10	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)	547	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)	80	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)	10	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,266,224	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)	285,346	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,980,878	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,980,878	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)	3,170.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,734,269	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)	1,734,269	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	828,973	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,563,242	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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)	253,641	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	31,705	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	285,346	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)	524	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,170.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,661,347	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

	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	366,737	5,266,224	0.069639	1,661,347	115,695	90.00
91.00	Nursing School cost	0	5,266,224	0.000000	1,661,347	0	91.00
92.00	Allied health cost	0	5,266,224	0.000000	1,661,347	0	92.00
93.00	All other Medical Education	0	5,266,224	0.000000	1,661,347	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D-3 | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		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		743,700		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.617576	243,325	150,272	50.00
53.00	05300	ANESTHESIOLOGY	0.084713	40,260	3,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217438	238,497	51,858	54.00
60.00	06000	LABORATORY	0.326996	449,130	146,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.762271	19,900	15,169	62.00
64.00	06400	INTRAVENOUS THERAPY	1.627540	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.319905	86,366	113,995	65.00
66.00	06600	PHYSICAL THERAPY	0.475199	47,249	22,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.719784	9,173	6,603	67.00
69.00	06900	ELECTROCARDIOLOGY	0.068236	12,358	843	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.609323	153,748	93,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.935380	51,555	48,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241021	728,562	175,599	73.00
76.00	03950	DIABETIC SERVICES	2.809634	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2.469002	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.641109	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970713	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,080,123	828,973	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)		2,080,123		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet D-3

Component CCN: 14-Z312 | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.617576	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.084713	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217438	11,666	2,537	54.00
60.00	06000	LABORATORY	0.326996	27,389	8,956	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.762271	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.627540	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.319905	2,760	3,643	65.00
66.00	06600	PHYSICAL THERAPY	0.475199	31,870	15,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.719784	8,631	6,212	67.00
69.00	06900	ELECTROCARDIOLOGY	0.068236	668	46	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.609323	4,360	2,657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.935380	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241021	37,667	9,079	73.00
76.00	03950	DIABETIC SERVICES	2.809634	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2.469002	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.641109	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.970713	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		125,011	48,275	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)		125,011		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 9/15/2021 3:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,525,425	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,525,425	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,600,679	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	39,229	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,182,772	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)	4,378,678	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)	4,378,678	30.00
31.00	Primary payer payments	4,319	31.00
32.00	Subtotal (line 30 minus line 31)	4,374,359	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)	859,761	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	558,845	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	719,572	36.00
37.00	Subtotal (see instructions)	4,933,204	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,933,204	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,050,774	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-117,570	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,180,860		4,824,774	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	12/30/2020	272,900	12/30/2020	226,000	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)		272,900		226,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,453,760		5,050,774	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		18,281		117,570	6.02
7.00	Total Medicare program liability (see instructions)		2,435,479		4,933,204	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: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Swing Beds - SNF | Cost

		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		295,266		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	12/30/2020	65,200		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)		65,200		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)		360,466		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		23,509		0	6.02
7.00	Total Medicare program liability (see instructions)		336,957		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: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet E-1 Part II Date/Time Prepared: 9/15/2021 3:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet E-2 | Date/Time Prepared: 9/15/2021 3:43 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	288,199	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	48,758	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	90	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	336,957	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	336,957	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	336,957	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	336,957	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	336,957	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	360,466	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-23,509	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part V Date/Time Prepared: 9/15/2021 3:43 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,563,242	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,563,242	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,588,874	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,588,874	19.00
20.00	Deductibles (exclude professional component)	198,448	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,390,426	22.00
23.00	Coinsurance	352	23.00
24.00	Subtotal (line 22 minus line 23)	2,390,074	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	69,854	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	45,405	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,356	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,435,479	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,435,479	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,453,760	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-18,281	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet G | Date/Time Prepared: 9/15/2021 3:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	21,320,161	0	0	0	1.00
2.00	Temporary investments	17,576,785	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,319,250	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	375,414	0	0	0	7.00
8.00	Prepaid expenses	1,021,302	0	0	0	8.00
9.00	Other current assets	305,507	0	0	0	9.00
10.00	Due from other funds	54,747	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	44,973,166	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,684,161	0	0	0	12.00
13.00	Land improvements	1,486,257	0	0	0	13.00
14.00	Accumulated depreciation	-1,144,967	0	0	0	14.00
15.00	Buildings	22,016,796	0	0	0	15.00
16.00	Accumulated depreciation	-12,344,125	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	4,292,012	0	0	0	19.00
20.00	Accumulated depreciation	-2,288,076	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	10,835,252	0	0	0	23.00
24.00	Accumulated depreciation	-7,466,762	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	2,808,025	0	0	0	27.00
28.00	Accumulated depreciation	-2,808,025	0	0	0	28.00
29.00	Minor equipment-nondepreciable	18,367	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,088,915	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	90,513	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	90,513	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,152,594	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	561,652	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,709,061	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,950,000	0	0	0	40.00
41.00	Deferred income	1,258,122	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,277,220	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,756,055	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,466,820	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	84,023	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,550,843	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,306,898	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	50,845,696				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)	50,845,696	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,152,594	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet G-1 | Date/Time Prepared: 9/15/2021 3:43 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		42,370,244		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,335,452				2.00
3.00	Total (sum of line 1 and line 2)		50,705,696		0		3.00
4.00	PRIOR PERIOD ADJUSTMENTS	140,000		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)		140,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		50,845,696		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)		50,845,696		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	PRIOR PERIOD ADJUSTMENTS		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: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/15/2021 3:43 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,424,750		1,424,750	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	112,500		112,500	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,537,250		1,537,250	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	1,537,250		1,537,250	17.00
18.00	Ancillary services	4,328,923	49,715,715	54,044,638	18.00
19.00	Outpatient services	0	8,276,296	8,276,296	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEE CHARGES	0	2,943,969	2,943,969	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,866,173	60,935,980	66,802,153	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,703,115		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)		35,703,115		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2020 To 04/30/2021 | Worksheet G-3 | Date/Time Prepared: 9/15/2021 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,802,153	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,820,347	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,981,806	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,703,115	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,278,691	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	27,830	6.00
7.00	Income from investments	397,434	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	93,029	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	4,056	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	55,587	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAINS ON INVESTMENTS	3,760,761	24.00
24.01	340B INCOME	16,525	24.01
24.02	MISCELLANEOUS INCOME	75,317	24.02
24.50	COVID-19 PHE Funding	2,634,635	24.50
25.00	Total other income (sum of lines 6-24)	7,065,174	25.00
26.00	Total (line 5 plus line 25)	8,343,865	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	8,413	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	8,413	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,335,452	29.00