

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: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet S Parts I-III Date/Time Prepared: 8/23/2021 11:49 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/23/2021	Time: 11:49 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SAINT JOSEPH MEMORIAL HOSPITAL (14-1334) for the cost reporting period beginning 04/01/2020 and ending 03/31/2021 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.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	265,967	1,013,083	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	-101,501	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	164,466	1,013,083	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: 14-1334		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 11:45 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 2 SOUTH HOSPITAL DRIVE			PO Box:				1.00				
2.00	City: MURPHYSBORO			State: IL		Zip Code: 62966		County: JACKSON				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			SAINT JOSEPH MEMORIAL HOSPITAL	141334	16060	1	05/01/2004	N	0	0	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			SAINT JOSEPH HOSPITAL SWING BED	14Z334	16060		11/14/2013	N	0	0	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)						04/01/2020	03/31/2021		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.					3	N			23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1334		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 11:45 am		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						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 adjustment? Enter "Y" for yes or "N" for no in column 2.				N				60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/23/2021 11:45 am

	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)					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: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/23/2021 11:45 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	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: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 11:45 am	
			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	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	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 11:45 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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:	585,297	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1334		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 11:45 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101					
142.00	Street: 1239 E. MAIN STREET	PO Box: 3988							
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988					
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	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: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/23/2021 11:45 am	
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N 1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
			Part A		Part B
			Y/N 1.00	Date 2.00	Y/N 3.00
					Date 4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/21/2021	Y	06/21/2021
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	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/23/2021 11:45 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
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		Y	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.		Y	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		Y	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.			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.		Y	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	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.	LUANNE	WARREN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SIH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
8/23/2021 11:45 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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

Health Financial Systems		SAINT JOSEPH MEMORIAL HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part IX Date/Time Prepared: 8/23/2021 11:45 am	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State		
			1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	23,364.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	23,364.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	23,364.00	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)		25			0	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	575	23	963			1.00
2.00	HMO and other (see instructions)	140	114				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	2,533	0	3,193			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	227			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,108	23	4,383			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)	3,108	23	4,383	0.00	193.74	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	193.74	27.00
28.00	Observation Bed Days		2	324			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: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	183	7	320	1.00
2.00 HMO and other (see instructions)			48	41		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	183	7	320	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet S-10

Date/Time Prepared:
8/23/2021 11:45 am

			8/23/2021 11:45 am	
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.237748	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		8,881,214	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,685,745	5.00
6.00	Medicaid charges		45,774,497	6.00
7.00	Medicaid cost (line 1 times line 6)		10,882,795	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)		0	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		11,659	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,675,327	616,770	2,292,097
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	398,306	616,770	1,015,076
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	398,306	616,770	1,015,076
			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	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,233,388	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,342,040	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,064,678	
28.00	Non-Medicare bad debt expense (see instructions)		2,168,710	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,238,244	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,253,320	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,253,320	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,483,522	1,483,522	115,934	1,599,456	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,742,175	1,742,175	62,426	1,804,601	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,757	4,489,319	4,550,076	0	4,550,076	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	40,001	12,006	52,007	0	52,007	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	392,766	21,108	413,874	0	413,874	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,077,967	3,226,061	4,304,028	-73	4,303,955	5.04
6.00	00600	MAINTENANCE & REPAIRS	252,869	579,175	832,044	0	832,044	6.00
7.00	00700	OPERATION OF PLANT	168,108	14,741	182,849	0	182,849	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	280,780	280,780	0	280,780	8.00
9.00	00900	HOUSEKEEPING	279,089	101,939	381,028	-172	380,856	9.00
10.00	01000	DIETARY	326,120	156,329	482,449	-324,064	158,385	10.00
11.00	01100	CAFETERIA	0	0	0	322,982	322,982	11.00
13.00	01300	NURSING ADMINISTRATION	1,058,856	28,103	1,086,959	0	1,086,959	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,556	185	31,741	0	31,741	14.00
15.00	01500	PHARMACY	453,098	7,988,389	8,441,487	-38,796	8,402,691	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,859	188	26,047	0	26,047	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	999,062	999,062	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,885,427	1,107,864	2,993,291	-26,404	2,966,887	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,069,839	4,134,588	6,204,427	-3,000,113	3,204,314	50.00
51.00	05100	RECOVERY ROOM	134,228	4,746	138,974	-494	138,480	51.00
53.00	05300	ANESTHESIOLOGY	0	1,027,521	1,027,521	-1,007,979	19,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	948,627	595,629	1,544,256	-41,911	1,502,345	54.00
60.00	06000	LABORATORY	656,169	1,614,174	2,270,343	0	2,270,343	60.00
64.00	06400	INTRAVENOUS THERAPY	724,938	196,403	921,341	-12,011	909,330	64.00
65.00	06500	RESPIRATORY THERAPY	406,586	101,571	508,157	-42,113	466,044	65.00
65.01	03610	SLEEP LAB	546,323	159,378	705,701	0	705,701	65.01
65.02	03620	GERIATRIC PSYCH	0	403,429	403,429	0	403,429	65.02
66.00	06600	PHYSICAL THERAPY	961,350	395,963	1,357,313	0	1,357,313	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,152,041	1,152,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,914,260	1,914,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	175,363	175,363	73.00
76.97	07697	CARDIAC REHABILITATION	212,240	11,688	223,928	0	223,928	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	231,565	93,069	324,634	-54,235	270,399	90.00
91.00	09100	EMERGENCY	1,163,660	2,503,467	3,667,127	-15,343	3,651,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		439,675	439,675	-178,360	261,315	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,107,998	32,913,185	47,021,183	0	47,021,183	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,927	50,927	0	50,927	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,107,998	32,964,112	47,072,110	0	47,072,110	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,705	1,679,161	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,304,279	3,108,880	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,072,892	3,477,184	4.00
5.01	00550	DATA PROCESSING	3,089,058	3,089,058	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-3,093	48,914	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	654,518	1,068,392	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	586,130	4,890,085	5.04
6.00	00600	MAINTENANCE & REPAIRS	-16,204	815,840	6.00
7.00	00700	OPERATION OF PLANT	0	182,849	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	280,780	8.00
9.00	00900	HOUSEKEEPING	0	380,856	9.00
10.00	01000	DIETARY	0	158,385	10.00
11.00	01100	CAFETERIA	-123,294	199,688	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,086,959	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,741	14.00
15.00	01500	PHARMACY	0	8,402,691	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,617	18,430	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-999,062	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-689,553	2,277,334	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-416	3,203,898	50.00
51.00	05100	RECOVERY ROOM	0	138,480	51.00
53.00	05300	ANESTHESIOLOGY	0	19,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-32,677	1,469,668	54.00
60.00	06000	LABORATORY	-187,391	2,082,952	60.00
64.00	06400	INTRAVENOUS THERAPY	0	909,330	64.00
65.00	06500	RESPIRATORY THERAPY	0	466,044	65.00
65.01	03610	SLEEP LAB	-9,599	696,102	65.01
65.02	03620	GERIATRIC PSYCH	0	403,429	65.02
66.00	06600	PHYSICAL THERAPY	-562	1,356,751	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,152,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,914,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	175,363	73.00
76.97	07697	CARDIAC REHABILITATION	0	223,928	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	270,399	90.00
91.00	09100	EMERGENCY	-2,210,380	1,441,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-261,315	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,635	47,120,818	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-8,336	42,591	192.00
192.01	19201	UNUSED SPACE	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	91,299	47,163,409	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet Non-CMS W
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	03610	SLEEP LAB	65.01
65.02	GERIATRIC PSYCH	03620	STRESS TEST	65.02
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	UNUSED SPACE	19201		192.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/23/2021 11:45 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - DIETARY RECLASS					
1.00	CAFETERIA	11.00	218,816	104,892	1.00
	TOTALS		218,816	104,892	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,066,301	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	3,066,301	
C - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	102,401	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	102,401	
D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115,934	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	62,426	2.00
	TOTALS		0	178,360	
E - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,914,260	1.00
	TOTALS		0	1,914,260	
F - CONTRAST RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	72,962	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	72,962	
G - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	999,062	1.00
	TOTALS		0	999,062	
500.00	Grand Total: Increases		218,816	6,438,238	500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/23/2021 11:45 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY RECLASS						
1.00	DIETARY	10.00	218,816	104,892	0		1.00
	TOTALS		218,816	104,892			
	B - MEDICAL SUPPLY RECLASS						
1.00	OPERATING ROOM	50.00	0	2,958,843	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	6,851	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	34,017	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	2,599	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,840	0		5.00
6.00	RECOVERY ROOM	51.00	0	11	0		6.00
7.00	CLINIC	90.00	0	54,233	0		7.00
8.00	HOUSEKEEPING	9.00	0	172	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13	0		9.00
10.00	EMERGENCY	91.00	0	6,017	0		10.00
11.00	PHARMACY	15.00	0	705	0		11.00
	TOTALS		0	3,066,301			
	C - DRUGS CHARGED TO PATIENTS						
1.00	DIETARY	10.00	0	356	0		1.00
2.00	CAFETERIA	11.00	0	726	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	23,564	0		3.00
4.00	OPERATING ROOM	50.00	0	17,207	0		4.00
5.00	RECOVERY ROOM	51.00	0	483	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	2,066	0		6.00
7.00	EMERGENCY	91.00	0	9,326	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	9,412	0		8.00
9.00	PHARMACY	15.00	0	38,091	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,095	0		10.00
11.00	CLINIC	90.00	0	2	0		11.00
12.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	73	0		12.00
	TOTALS		0	102,401			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	178,360	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	178,360			
	E - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,914,260	0		1.00
	TOTALS		0	1,914,260			
	F - CONTRAST RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	40,803	0		1.00
2.00	OPERATING ROOM	50.00	0	24,063	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	8,096	0		3.00
	TOTALS		0	72,962			
	G - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	999,062	0		1.00
	TOTALS		0	999,062			
500.00	Grand Total: Decreases		218,816	6,438,238			500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/23/2021 11:45 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - DIETARY RECLASS									
1.00	CAFETERIA	11.00	218,816	104,892	DIETARY	10.00	218,816	104,892	1.00
	TOTALS		218,816	104,892	TOTALS		218,816	104,892	
B - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES	71.00	0	3,066,301	OPERATING ROOM	50.00	0	2,958,843	1.00
	CHARGED TO PATIENTS								
2.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	6,851	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	34,017	3.00
4.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	2,599	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	2,840	5.00
6.00		0.00	0	0	RECOVERY ROOM	51.00	0	11	6.00
7.00		0.00	0	0	CLINIC	90.00	0	54,233	7.00
8.00		0.00	0	0	HOUSEKEEPING	9.00	0	172	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	13	9.00
10.00		0.00	0	0	EMERGENCY	91.00	0	6,017	10.00
11.00		0.00	0	0	PHARMACY	15.00	0	705	11.00
	TOTALS		0	3,066,301	TOTALS		0	3,066,301	
C - DRUGS CHARGED TO PATIENTS									
1.00	DRUGS CHARGED TO	73.00	0	102,401	DIETARY	10.00	0	356	1.00
	PATIENTS								
2.00		0.00	0	0	CAFETERIA	11.00	0	726	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	23,564	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	17,207	4.00
5.00		0.00	0	0	RECOVERY ROOM	51.00	0	483	5.00
6.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	2,066	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	9,326	7.00
8.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	9,412	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	38,091	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,095	10.00
11.00		0.00	0	0	CLINIC	90.00	0	2	11.00
12.00		0.00	0	0	OTHER ADMINISTRATIVE	5.04	0	73	12.00
	TOTALS		0	102,401	TOTALS		0	102,401	
D - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG &	1.00	0	115,934	INTEREST EXPENSE	113.00	0	178,360	1.00
	FIXT								
2.00	CAP REL COSTS-MVBLE	2.00	0	62,426		0.00	0	0	2.00
	EQUIP								
	TOTALS		0	178,360	TOTALS		0	178,360	
E - IMPLANTABLE DEVICE RECLASS									
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,914,260	MEDICAL SUPPLIES	71.00	0	1,914,260	1.00
	PATIENTS				CHARGED TO PATIENTS				
	TOTALS		0	1,914,260	TOTALS		0	1,914,260	
F - CONTRAST RECLASS									
1.00	DRUGS CHARGED TO	73.00	0	72,962	RADIOLOGY-DIAGNOSTIC	54.00	0	40,803	1.00
	PATIENTS								
2.00		0.00	0	0	OPERATING ROOM	50.00	0	24,063	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	8,096	3.00
	TOTALS		0	72,962	TOTALS		0	72,962	
G - CRNA RECLASS									
1.00	NONPHYSICIAN	19.00	0	999,062	ANESTHESIOLOGY	53.00	0	999,062	1.00
	ANESTHETISTS								
	TOTALS		0	999,062	TOTALS		0	999,062	
500.00	Grand Total:		218,816	6,438,238	Grand Total:		218,816	6,438,238	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part I
Date/Time Prepared:
8/23/2021 11:45 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	171,136	8,250	0	8,250	0	1.00	
2.00	Land Improvements	1,198,731	5,685	0	5,685	0	2.00	
3.00	Buildings and Fixtures	30,138,031	3,061,916	0	3,061,916	266,676	3.00	
4.00	Building Improvements	2,333	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	17,521,034	2,487,088	0	2,487,088	2,672,307	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	49,031,265	5,562,939	0	5,562,939	2,938,983	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	49,031,265	5,562,939	0	5,562,939	2,938,983	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	179,386	0					1.00
2.00	Land Improvements	1,204,416	0					
3.00	Buildings and Fixtures	32,933,271	0					
4.00	Building Improvements	2,333	0					4.00
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	17,335,815	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	51,655,221	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	51,655,221	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part II
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,483,522	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,742,175	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,225,697	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,483,522				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,742,175				2.00
3.00	Total (sum of lines 1-2)	0	3,225,697				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part III
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	34,319,406	0	34,319,406	0.664394	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,335,816	0	17,335,816	0.335606	0	2.00
3.00	Total (sum of lines 1-2)	51,655,222	0	51,655,222	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,679,161	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,108,880	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,788,041	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	0	0	0	1,679,161	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,108,880	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,788,041	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)		0		0.00	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	-3,080,645			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	9,427,977			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-123,294	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	-7,617	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	A	-999,062	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/23/2021 11:45 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 PURCHASE DISCOUNTS	B	-3,093	PURCHASING RECEIVING AND STORES	5.02	0	33.00
33.01 EMPLOYEE OUTPATIENT INS PAYMENTS	B	-2,277,151	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02 LOBBYING EXPENSES	A	-14,494	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03 UNRESTRICTED INTEREST REVENUE	B	-135,669	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04 LEASEHOLD REVENUE	B	-35,037	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05 XRAY FILM REVENUE	B	-7	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06 SHAWNEE PARK DEPR.	A	-8,997	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07 NONALLOWABLE INTEST EXP.	A	-261,315	INTEREST EXPENSE	113.00	0	33.07
33.08 REAL ESTATE TAXES	A	-5,632	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.08
33.09 MEDICAID PROVIDER TAX	A	-2,355,595	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.10 CABLE TV	A	-2,001	SLEEP LAB	65.01	0	33.10
33.11 CABLE TV	A	-16,204	MAINTENANCE & REPAIRS	6.00	0	33.11
33.12 SHAWNEE PARK PROPERTY INS	A	-661	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13 REAL ESTATE TAXES	A	-6,938	SLEEP LAB	65.01	0	33.13
33.14 SHAWNEE PARK REAL ESTATE TAXES	A	-2,704	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.14
33.15 CABLE TV	A	-562	PHYSICAL THERAPY	66.00	0	33.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		91,299				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-1

Date/Time Prepared:
8/23/2021 11:45 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE EXPENSE	123,739	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE EXPENSE	1,304,279	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EXPENSE	1,204,259	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE EXPENSE	3,089,058	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE EXPENSE	654,518	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE EXPENSE	3,097,279	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RENT	57,726	90,396	4.03
4.04	60.00	LABORATORY	RENT	22,051	34,536	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,552,909	124,932	5.00

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

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

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

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

6.00	B	SIHS	100.00	RELATED ORG	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYMAN	100.00	RELATED ORG	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-1

Date/Time Prepared:
8/23/2021 11:45 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	123,739	9		1.00
2.00	1,304,279	9		2.00
3.00	1,204,259	0		3.00
4.00	3,089,058	0		4.00
4.01	654,518	0		4.01
4.02	3,097,279	0		4.02
4.03	-32,670	0		4.03
4.04	-12,485	0		4.04
5.00	9,427,977			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-2

Date/Time Prepared:
8/23/2021 11:45 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	DR. A	2,210,380	2,210,380	0	0	0	1.00
2.00	60.00	DR. B	174,906	174,906	0	0	0	2.00
3.00	76.97	DR. C	3,900	0	3,900	0	0	3.00
4.00	65.01	DR. D	17,765	660	17,105	0	0	4.00
5.00	30.00	DR. E	689,553	689,553	0	0	0	5.00
6.00	5.04	DR. F	4,730	4,730	0	0	0	6.00
7.00	50.00	DR. G	19,448	416	19,032	0	0	7.00
8.00	90.00	DR. H	2,120	0	2,120	0	0	8.00
9.00	65.00	DR. I	1,769	0	1,769	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,124,571	3,080,645	43,926		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	91.00	DR. A	0	0	0	0	0	1.00
2.00	60.00	DR. B	0	0	0	0	0	2.00
3.00	76.97	DR. C	0	0	0	0	0	3.00
4.00	65.01	DR. D	0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	5.04	DR. F	0	0	0	0	0	6.00
7.00	50.00	DR. G	0	0	0	0	0	7.00
8.00	90.00	DR. H	0	0	0	0	0	8.00
9.00	65.00	DR. I	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	91.00	DR. A	0	0	0	2,210,380		1.00
2.00	60.00	DR. B	0	0	0	174,906		2.00
3.00	76.97	DR. C	0	0	0	0		3.00
4.00	65.01	DR. D	0	0	0	660		4.00
5.00	30.00	DR. E	0	0	0	689,553		5.00
6.00	5.04	DR. F	0	0	0	4,730		6.00
7.00	50.00	DR. G	0	0	0	416		7.00
8.00	90.00	DR. H	0	0	0	0		8.00
9.00	65.00	DR. I	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,080,645		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				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	1,679,161	1,679,161				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,108,880		3,108,880			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,477,184	15,690	29,049	3,521,923		4.00
5.01	00550	DATA PROCESSING	3,089,058	7,482	13,853	0	3,110,393	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	48,914	7,396	13,693	10,029	9,148	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,068,392	22,204	41,110	98,474	164,668	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,890,085	333,326	617,135	270,268	247,002	5.04
6.00	00600	MAINTENANCE & REPAIRS	815,840	168,720	312,376	63,399	91,482	6.00
7.00	00700	OPERATION OF PLANT	182,849	2,523	4,671	42,148	36,593	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	280,780	11,647	21,563	0	0	8.00
9.00	00900	HOUSEKEEPING	380,856	11,318	20,955	69,973	18,296	9.00
10.00	01000	DIETARY	158,385	81,612	151,101	26,903	64,038	10.00
11.00	01100	CAFETERIA	199,688	8,121	15,037	54,862	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,086,959	38,378	71,056	265,476	45,741	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,741	8,070	14,941	7,912	0	14.00
15.00	01500	PHARMACY	8,402,691	17,349	32,121	113,601	45,741	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,430	80,230	148,542	6,483	36,593	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,277,334	146,273	270,817	472,714	439,114	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,203,898	222,563	412,065	518,949	576,337	50.00
51.00	05100	RECOVERY ROOM	138,480	24,555	45,461	33,654	36,593	51.00
53.00	05300	ANESTHESIOLOGY	19,542	1,348	2,495	0	9,148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,469,668	88,749	164,314	237,840	173,816	54.00
60.00	06000	LABORATORY	2,082,952	40,573	75,119	164,515	146,371	60.00
64.00	06400	INTRAVENOUS THERAPY	909,330	48,038	88,939	181,756	192,113	64.00
65.00	06500	RESPIRATORY THERAPY	466,044	11,353	21,019	101,939	73,186	65.00
65.01	03610	SLEEP LAB	696,102	65,421	121,124	136,974	137,223	65.01
65.02	03620	GERIATRIC PSYCH	403,429	20,909	38,711	0	45,741	65.02
66.00	06600	PHYSICAL THERAPY	1,356,751	20,736	38,391	241,030	164,668	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,152,041	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,914,260	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	175,363	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	223,928	32,693	60,530	53,213	45,741	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	270,399	44,150	81,741	58,058	118,927	90.00
91.00	09100	EMERGENCY	1,441,404	82,027	151,869	291,753	192,113	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)	47,120,818	1,663,454	3,079,798	3,521,923	3,110,393	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,551	13,981	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,591	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	8,156	15,101	0	0	192.01
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)	47,163,409	1,679,161	3,108,880	3,521,923	3,110,393	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	89,180					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	640	1,395,488				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	56	0	6,357,872	6,357,872		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,451,817	226,206	1,678,023	6.00
7.00	00700	OPERATION OF PLANT	0	0	268,784	41,879	3,765	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	313,990	48,922	17,382	8.00
9.00	00900	HOUSEKEEPING	0	0	501,398	78,122	16,892	9.00
10.00	01000	DIETARY	17	0	482,056	75,109	121,802	10.00
11.00	01100	CAFETERIA	34	0	277,742	43,275	12,121	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,507,610	234,899	57,278	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4	0	62,668	9,764	12,044	14.00
15.00	01500	PHARMACY	1,229	0	8,612,732	1,341,943	25,892	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	290,278	45,228	119,739	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,792	24,559	3,640,603	567,239	218,305	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,849	344,611	5,329,272	830,349	332,165	50.00
51.00	05100	RECOVERY ROOM	106	10,082	288,931	45,018	36,646	51.00
53.00	05300	ANESTHESIOLOGY	1,688	49,577	83,798	13,056	2,012	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,352	254,522	2,392,261	372,736	132,453	54.00
60.00	06000	LABORATORY	3,538	227,687	2,740,755	427,034	60,553	60.00
64.00	06400	INTRAVENOUS THERAPY	7,272	26,268	1,453,716	226,502	71,694	64.00
65.00	06500	RESPIRATORY THERAPY	740	25,091	699,372	108,968	16,943	65.00
65.01	03610	SLEEP LAB	139	35,558	1,192,541	185,809	97,638	65.01
65.02	03620	GERIATRIC PSYCH	3	1,427	510,220	79,497	31,205	65.02
66.00	06600	PHYSICAL THERAPY	281	48,543	1,870,400	291,425	30,947	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,485	1,183,526	184,404	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,060	1,955,320	304,656	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	188,769	364,132	56,735	0	73.00
76.97	07697	CARDIAC REHABILITATION	112	4,657	420,874	65,576	48,793	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,306	17,089	591,670	92,188	65,891	90.00
91.00	09100	EMERGENCY	8,022	64,503	2,231,691	347,718	122,421	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)	89,180	1,395,488	47,076,029	6,344,257	1,654,581	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,532	3,355	11,270	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	42,591	6,636	0	192.00
192.01	19201	UNUSED SPACE	0	0	23,257	3,624	12,172	192.01
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)	89,180	1,395,488	47,163,409	6,357,872	1,678,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	314,428					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,264	383,558				8.00
9.00	00900	HOUSEKEEPING	3,172	740	600,324			9.00
10.00	01000	DIETARY	22,875	136	0	701,978		10.00
11.00	01100	CAFETERIA	2,276	0	7,434	0	342,848	11.00
13.00	01300	NURSING ADMINISTRATION	10,757	0	0	0	23,165	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,262	0	0	0	2,317	14.00
15.00	01500	PHARMACY	4,863	0	4,796	0	9,266	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,487	0	1,439	0	2,317	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,998	132,018	194,952	701,978	62,547	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,382	47,095	139,560	0	67,178	50.00
51.00	05100	RECOVERY ROOM	6,882	16,208	8,033	0	2,317	51.00
53.00	05300	ANESTHESIOLOGY	378	0	360	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,875	55,224	28,775	0	32,432	54.00
60.00	06000	LABORATORY	11,372	0	7,673	0	25,482	60.00
64.00	06400	INTRAVENOUS THERAPY	13,464	0	43,163	0	20,849	64.00
65.00	06500	RESPIRATORY THERAPY	3,182	1,100	4,316	0	11,583	65.00
65.01	03610	SLEEP LAB	18,337	526	9,832	0	13,899	65.01
65.02	03620	GERIATRIC PSYCH	5,860	0	5,995	0	0	65.02
66.00	06600	PHYSICAL THERAPY	5,812	0	0	0	27,798	66.00
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
76.97	07697	CARDIAC REHABILITATION	9,163	127	7,314	0	6,950	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12,374	5,617	21,581	0	6,950	90.00
91.00	09100	EMERGENCY	22,991	124,767	115,101	0	27,798	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)	310,026	383,558	600,324	701,978	342,848	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,116	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	2,286	0	0	0	0	192.01
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)	314,428	383,558	600,324	701,978	342,848	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,833,709					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	89,055				14.00
15.00	01500	PHARMACY	102,086	55	10,101,633			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	481,488		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	674,095	167	30,120	8,475	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	730,138	84,985	24,516	118,832	0	50.00
51.00	05100	RECOVERY ROOM	35,308	1	617	3,479	0	51.00
53.00	05300	ANESTHESIOLOGY	0	530	2,640	17,109	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1	1,399	87,835	0	54.00
60.00	06000	LABORATORY	0	0	0	78,575	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	201	45,953	9,065	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,630	0	8,659	0	65.00
65.01	03610	SLEEP LAB	0	0	0	12,271	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	493	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	16,752	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,865	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	0	0	9,971,799	65,144	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,607	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	20	6,590	5,897	0	90.00
91.00	09100	EMERGENCY	292,082	465	17,999	22,260	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)	1,833,709	89,055	10,101,633	481,488	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,833,709	89,055	10,101,633	481,488	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,271,497	0	6,271,497	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,766,472	0	7,766,472	50.00
51.00	05100	RECOVERY ROOM	443,440	0	443,440	51.00
53.00	05300	ANESTHESIOLOGY	119,883	0	119,883	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,127,991	0	3,127,991	54.00
60.00	06000	LABORATORY	3,351,444	0	3,351,444	60.00
64.00	06400	INTRAVENOUS THERAPY	1,884,607	0	1,884,607	64.00
65.00	06500	RESPIRATORY THERAPY	856,753	0	856,753	65.00
65.01	03610	SLEEP LAB	1,530,853	0	1,530,853	65.01
65.02	03620	GERIATRIC PSYCH	633,270	0	633,270	65.02
66.00	06600	PHYSICAL THERAPY	2,243,134	0	2,243,134	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,378,795	0	1,378,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,274,146	0	2,274,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,457,810	0	10,457,810	73.00
76.97	07697	CARDIAC REHABILITATION	560,404	0	560,404	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	808,778	0	808,778	90.00
91.00	09100	EMERGENCY	3,325,293	0	3,325,293	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)	47,034,570	0	47,034,570	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,273	0	38,273	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,227	0	49,227	192.00
192.01	19201	UNUSED SPACE	41,339	0	41,339	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	47,163,409	0	47,163,409	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1334

Period:

From 04/01/2020

To 03/31/2021

Worksheet Non-CMS W

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,690	29,049	44,739	4.00
5.01	00550	DATA PROCESSING	0	7,482	13,853	21,335	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	7,396	13,693	21,089	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	22,204	41,110	63,314	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	333,326	617,135	950,461	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	168,720	312,376	481,096	6.00
7.00	00700	OPERATION OF PLANT	0	2,523	4,671	7,194	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,647	21,563	33,210	8.00
9.00	00900	HOUSEKEEPING	0	11,318	20,955	32,273	9.00
10.00	01000	DIETARY	0	81,612	151,101	232,713	10.00
11.00	01100	CAFETERIA	0	8,121	15,037	23,158	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,378	71,056	109,434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,070	14,941	23,011	14.00
15.00	01500	PHARMACY	0	17,349	32,121	49,470	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,230	148,542	228,772	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	146,273	270,817	417,090	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	222,563	412,065	634,628	50.00
51.00	05100	RECOVERY ROOM	0	24,555	45,461	70,016	51.00
53.00	05300	ANESTHESIOLOGY	0	1,348	2,495	3,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,749	164,314	253,063	54.00
60.00	06000	LABORATORY	0	40,573	75,119	115,692	60.00
64.00	06400	INTRAVENOUS THERAPY	0	48,038	88,939	136,977	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,353	21,019	32,372	65.00
65.01	03610	SLEEP LAB	0	65,421	121,124	186,545	65.01
65.02	03620	GERIATRIC PSYCH	0	20,909	38,711	59,620	65.02
66.00	06600	PHYSICAL THERAPY	0	20,736	38,391	59,127	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	32,693	60,530	93,223	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	44,150	81,741	125,891	90.00
91.00	09100	EMERGENCY	0	82,027	151,869	233,896	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	1,663,454	3,079,798	4,743,252	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,551	13,981	21,532	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	8,156	15,101	23,257	192.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,679,161	3,108,880	4,788,041	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
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	00550	DATA PROCESSING	21,335					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	63	21,279				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,130	153	65,848			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,694	13	0	955,601		5.04
6.00	00600	MAINTENANCE & REPAIRS	628	0	0	33,999	516,528	6.00
7.00	00700	OPERATION OF PLANT	251	0	0	6,294	1,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	7,353	5,350	8.00
9.00	00900	HOUSEKEEPING	126	0	0	11,742	5,200	9.00
10.00	01000	DIETARY	439	4	0	11,289	37,493	10.00
11.00	01100	CAFETERIA	0	8	0	6,504	3,731	11.00
13.00	01300	NURSING ADMINISTRATION	314	0	0	35,305	17,631	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1	0	1,468	3,707	14.00
15.00	01500	PHARMACY	314	293	0	201,709	7,970	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	251	0	0	6,798	36,858	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,012	2,336	1,158	85,256	67,199	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,950	12,133	16,283	124,801	102,247	50.00
51.00	05100	RECOVERY ROOM	251	25	476	6,766	11,280	51.00
53.00	05300	ANESTHESIOLOGY	63	403	2,338	1,962	619	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,192	800	12,005	56,022	40,772	54.00
60.00	06000	LABORATORY	1,004	844	10,739	64,183	18,639	60.00
64.00	06400	INTRAVENOUS THERAPY	1,318	1,735	1,239	34,043	22,069	64.00
65.00	06500	RESPIRATORY THERAPY	502	177	1,183	16,378	5,216	65.00
65.01	03610	SLEEP LAB	941	33	1,677	27,927	30,055	65.01
65.02	03620	GERIATRIC PSYCH	314	1	67	11,948	9,605	65.02
66.00	06600	PHYSICAL THERAPY	1,130	67	2,290	43,801	9,526	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,485	27,716	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,937	45,790	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,903	8,527	0	73.00
76.97	07697	CARDIAC REHABILITATION	314	27	220	9,856	15,019	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	816	312	806	13,856	20,283	90.00
91.00	09100	EMERGENCY	1,318	1,914	3,042	52,262	37,684	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)	21,335	21,279	65,848	953,555	509,312	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	504	3,469	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	997	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	545	3,747	192.01
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)	21,335	21,279	65,848	955,601	516,528	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	15,433					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	160	46,073				8.00
9.00	00900	HOUSEKEEPING	156	89	50,475			9.00
10.00	01000	DIETARY	1,123	16	0	283,419		10.00
11.00	01100	CAFETERIA	112	0	625	0	34,835	11.00
13.00	01300	NURSING ADMINISTRATION	528	0	0	0	2,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111	0	0	0	235	14.00
15.00	01500	PHARMACY	239	0	403	0	941	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,104	0	121	0	235	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,012	15,859	16,392	283,419	6,355	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,061	5,657	11,734	0	6,829	50.00
51.00	05100	RECOVERY ROOM	338	1,947	675	0	235	51.00
53.00	05300	ANESTHESIOLOGY	19	0	30	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,221	6,633	2,419	0	3,295	54.00
60.00	06000	LABORATORY	558	0	645	0	2,589	60.00
64.00	06400	INTRAVENOUS THERAPY	661	0	3,629	0	2,118	64.00
65.00	06500	RESPIRATORY THERAPY	156	132	363	0	1,177	65.00
65.01	03610	SLEEP LAB	900	63	827	0	1,412	65.01
65.02	03620	GERIATRIC PSYCH	288	0	504	0	0	65.02
66.00	06600	PHYSICAL THERAPY	285	0	0	0	2,824	66.00
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
76.97	07697	CARDIAC REHABILITATION	450	15	615	0	706	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	607	675	1,815	0	706	90.00
91.00	09100	EMERGENCY	1,128	14,987	9,678	0	2,824	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)	15,217	46,073	50,475	283,419	34,835	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	104	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	112	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,433	46,073	50,475	283,419	34,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	168,938					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,634				14.00
15.00	01500	PHARMACY	9,405	18	272,205			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	274,221		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	62,104	54	812	4,828		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,267	27,324	661	67,647		50.00
51.00	05100	RECOVERY ROOM	3,253	0	17	1,982		51.00
53.00	05300	ANESTHESIOLOGY	0	170	71	9,745		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	38	50,032		54.00
60.00	06000	LABORATORY	0	0	0	44,757		60.00
64.00	06400	INTRAVENOUS THERAPY	0	65	1,238	5,164		64.00
65.00	06500	RESPIRATORY THERAPY	0	846	0	4,932		65.00
65.01	03610	SLEEP LAB	0	0	0	6,990		65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	281		65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	9,542		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,189		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,071		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	268,705	37,107		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	915		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	7	178	3,359		90.00
91.00	09100	EMERGENCY	26,909	150	485	12,680		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)	168,938	28,634	272,205	274,221	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
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)	168,938	28,634	272,205	274,221	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	973,891	0	973,891	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,090,814	0	1,090,814	50.00
51.00	05100	RECOVERY ROOM	97,689	0	97,689	51.00
53.00	05300	ANESTHESIOLOGY	19,263	0	19,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	430,513	0	430,513	54.00
60.00	06000	LABORATORY	261,740	0	261,740	60.00
64.00	06400	INTRAVENOUS THERAPY	212,565	0	212,565	64.00
65.00	06500	RESPIRATORY THERAPY	64,729	0	64,729	65.00
65.01	03610	SLEEP LAB	259,110	0	259,110	65.01
65.02	03620	GERIATRIC PSYCH	82,628	0	82,628	65.02
66.00	06600	PHYSICAL THERAPY	131,654	0	131,654	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,390	0	35,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,798	0	55,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	323,242	0	323,242	73.00
76.97	07697	CARDIAC REHABILITATION	122,036	0	122,036	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	170,049	0	170,049	90.00
91.00	09100	EMERGENCY	402,663	0	402,663	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)	4,733,774	0	4,733,774	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,609	0	25,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	997	0	997	192.00
192.01	19201	UNUSED SPACE	27,661	0	27,661	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,788,041	0	4,788,041	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,175					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,175				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	908	908	14,047,241			4.00
5.01	00550	DATA PROCESSING	433	433	0	340		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	428	428	40,001	1	1,673,036	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,285	1,285	392,766	18	12,010	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	19,290	19,290	1,077,967	27	1,055	5.04
6.00	00600	MAINTENANCE & REPAIRS	9,764	9,764	252,869	10	3	6.00
7.00	00700	OPERATION OF PLANT	146	146	168,108	4	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	674	674	0	0	0	8.00
9.00	00900	HOUSEKEEPING	655	655	279,089	2	0	9.00
10.00	01000	DIETARY	4,723	4,723	107,304	7	313	10.00
11.00	01100	CAFETERIA	470	470	218,816	0	638	11.00
13.00	01300	NURSING ADMINISTRATION	2,221	2,221	1,058,856	5	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	467	31,556	0	81	14.00
15.00	01500	PHARMACY	1,004	1,004	453,098	5	23,059	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,643	4,643	25,859	4	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,465	8,465	1,885,427	48	183,695	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,880	12,880	2,069,839	63	953,947	50.00
51.00	05100	RECOVERY ROOM	1,421	1,421	134,228	4	1,991	51.00
53.00	05300	ANESTHESIOLOGY	78	78	0	1	31,659	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,136	5,136	948,627	19	62,893	54.00
60.00	06000	LABORATORY	2,348	2,348	656,169	16	66,368	60.00
64.00	06400	INTRAVENOUS THERAPY	2,780	2,780	724,938	21	136,419	64.00
65.00	06500	RESPIRATORY THERAPY	657	657	406,586	8	13,878	65.00
65.01	03610	SLEEP LAB	3,786	3,786	546,323	15	2,614	65.01
65.02	03620	GERIATRIC PSYCH	1,210	1,210	0	5	57	65.02
66.00	06600	PHYSICAL THERAPY	1,200	1,200	961,350	18	5,278	66.00
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
76.97	07697	CARDIAC REHABILITATION	1,892	1,892	212,240	5	2,092	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,555	2,555	231,565	13	24,492	90.00
91.00	09100	EMERGENCY	4,747	4,747	1,163,660	21	150,494	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)	96,266	96,266	14,047,241	340	1,673,036	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	437	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	472	472	0	0	0	192.01
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)	1,679,161	3,108,880	3,521,923	3,110,393	89,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.279763	31.992591	0.250720	9,148.214706	0.053304	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			44,739	21,335	21,279	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003185	62.750000	0.012719	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	204,408,562					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-6,357,872	40,805,537			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,451,817	65,067		6.00
7.00	00700	OPERATION OF PLANT	0	0	268,784	146	64,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	313,990	674	674	8.00
9.00	00900	HOUSEKEEPING	0	0	501,398	655	655	9.00
10.00	01000	DIETARY	0	0	482,056	4,723	4,723	10.00
11.00	01100	CAFETERIA	0	0	277,742	470	470	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,507,610	2,221	2,221	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	62,668	467	467	14.00
15.00	01500	PHARMACY	0	0	8,612,732	1,004	1,004	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	290,278	4,643	4,643	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,597,303	0	3,640,603	8,465	8,465	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,479,055	0	5,329,272	12,880	12,880	50.00
51.00	05100	RECOVERY ROOM	1,476,759	0	288,931	1,421	1,421	51.00
53.00	05300	ANESTHESIOLOGY	7,261,919	0	83,798	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,281,610	0	2,392,261	5,136	5,136	54.00
60.00	06000	LABORATORY	33,350,889	0	2,740,755	2,348	2,348	60.00
64.00	06400	INTRAVENOUS THERAPY	3,847,662	0	1,453,716	2,780	2,780	64.00
65.00	06500	RESPIRATORY THERAPY	3,675,225	0	699,372	657	657	65.00
65.01	03610	SLEEP LAB	5,208,504	0	1,192,541	3,786	3,786	65.01
65.02	03620	GERIATRIC PSYCH	209,065	0	510,220	1,210	1,210	65.02
66.00	06600	PHYSICAL THERAPY	7,110,488	0	1,870,400	1,200	1,200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,611,804	0	1,183,526	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,014,381	0	1,955,320	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,650,419	0	364,132	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	682,142	0	420,874	1,892	1,892	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,503,104	0	591,670	2,555	2,555	90.00
91.00	09100	EMERGENCY	9,448,233	0	2,231,691	4,747	4,747	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)	204,408,562	-6,357,872	40,718,157	64,158	64,012	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,532	437	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	42,591	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	23,257	472	472	192.01
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)	1,395,488		6,357,872	1,678,023	314,428	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006827		0.155809	25.789156	4.843240	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,848		955,601	516,528	15,433	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000322		0.023418	7.938402	0.237720	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
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	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,402					8.00
9.00	00900	HOUSEKEEPING	76	5,007				9.00
10.00	01000	DIETARY	14	0	16,852			10.00
11.00	01100	CAFETERIA	0	62	0	148		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	10	152,375	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1	0	14.00
15.00	01500	PHARMACY	0	40	0	4	8,483	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	0	1	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,562	1,626	16,852	27	56,015	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,838	1,164	0	29	60,672	50.00
51.00	05100	RECOVERY ROOM	1,665	67	0	1	2,934	51.00
53.00	05300	ANESTHESIOLOGY	0	3	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,673	240	0	14	0	54.00
60.00	06000	LABORATORY	0	64	0	11	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	360	0	9	0	64.00
65.00	06500	RESPIRATORY THERAPY	113	36	0	5	0	65.00
65.01	03610	SLEEP LAB	54	82	0	6	0	65.01
65.02	03620	GERIATRIC PSYCH	0	50	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	12	0	66.00
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
76.97	07697	CARDIAC REHABILITATION	13	61	0	3	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	577	180	0	3	0	90.00
91.00	09100	EMERGENCY	12,817	960	0	12	24,271	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)	39,402	5,007	16,852	148	152,375	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	383,558	600,324	701,978	342,848	1,833,709	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.734480	119.896944	41.655471	2,316.540541	12.034185	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,073	50,475	283,419	34,835	168,938	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.169306	10.080887	16.818122	235.371622	1.108699	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	19.00	
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	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,151,869				14.00
15.00	01500	PHARMACY	705	7,905,573			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	204,408,562		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,162	23,572	3,597,303	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,099,231	19,186	50,479,055	0	50.00
51.00	05100	RECOVERY ROOM	11	483	1,476,759	0	51.00
53.00	05300	ANESTHESIOLOGY	6,851	2,066	7,261,919	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13	1,095	37,281,610	0	54.00
60.00	06000	LABORATORY	0	0	33,350,889	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,599	35,963	3,847,662	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,017	0	3,675,225	0	65.00
65.01	03610	SLEEP LAB	0	0	5,208,504	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	209,065	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	7,110,488	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,611,804	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,014,381	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,803,965	27,650,419	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	682,142	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	263	5,157	2,503,104	0	90.00
91.00	09100	EMERGENCY	6,017	14,086	9,448,233	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)	1,151,869	7,905,573	204,408,562	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	192.01
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)	89,055	10,101,633	481,488	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.077313	1.277786	0.002356	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,634	272,205	274,221	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.024859	0.034432	0.001342	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 11:45 am

			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	6,271,497		6,271,497	0	0	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,766,472		7,766,472	0	0	50.00	
51.00	05100	RECOVERY ROOM	443,440		443,440	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	119,883		119,883	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,127,991		3,127,991	0	0	54.00	
60.00	06000	LABORATORY	3,351,444		3,351,444	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	1,884,607		1,884,607	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	856,753	0	856,753	0	0	65.00	
65.01	03610	SLEEP LAB	1,530,853	0	1,530,853	0	0	65.01	
65.02	03620	GERIATRIC PSYCH	633,270	0	633,270	0	0	65.02	
66.00	06600	PHYSICAL THERAPY	2,243,134	0	2,243,134	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,378,795		1,378,795	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,274,146		2,274,146	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	10,457,810		10,457,810	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	560,404		560,404	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	808,778		808,778	0	0	90.00	
91.00	09100	EMERGENCY	3,325,293		3,325,293	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	450,632		450,632		0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	47,485,202	0	47,485,202	0	0	200.00	
201.00		Less Observation Beds	450,632		450,632			201.00	
202.00		Total (see instructions)	47,034,570	0	47,034,570	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 11:45 am

				Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,981,547		2,981,547			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	427,936	48,632,788	49,060,724	0.158303	0.000000	50.00
51.00	05100	RECOVERY ROOM	47,856	1,082,510	1,130,366	0.392298	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	77,332	6,892,852	6,970,184	0.017199	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992,828	35,132,944	36,125,772	0.086586	0.000000	54.00
60.00	06000	LABORATORY	1,301,906	30,697,363	31,999,269	0.104735	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	30,018	3,754,977	3,784,995	0.497915	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,192,609	2,433,589	3,626,198	0.236268	0.000000	65.00
65.01	03610	SLEEP LAB	0	4,935,810	4,935,810	0.310152	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	209,065	209,065	3.029058	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	2,136,952	4,718,659	6,855,611	0.327197	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,552	4,463,114	4,520,666	0.304998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,939	5,873,785	5,944,724	0.382549	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,947,700	24,738,414	26,686,114	0.391882	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	662,644	662,644	0.845709	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,784	2,471,154	2,473,938	0.326919	0.000000	90.00
91.00	09100	EMERGENCY	161,953	9,104,114	9,266,067	0.358868	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,997	570,822	599,819	0.751280	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,458,909	186,374,604	197,833,513			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,458,909	186,374,604	197,833,513			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
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
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
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
76.97	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 11:45 am

			Title XIX		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	6,271,497		6,271,497	0	6,271,497	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,766,472		7,766,472	0	7,766,472	50.00	
51.00	05100	RECOVERY ROOM	443,440		443,440	0	443,440	51.00	
53.00	05300	ANESTHESIOLOGY	119,883		119,883	0	119,883	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,127,991		3,127,991	0	3,127,991	54.00	
60.00	06000	LABORATORY	3,351,444		3,351,444	0	3,351,444	60.00	
64.00	06400	INTRAVENOUS THERAPY	1,884,607		1,884,607	0	1,884,607	64.00	
65.00	06500	RESPIRATORY THERAPY	856,753	0	856,753	0	856,753	65.00	
65.01	03610	SLEEP LAB	1,530,853	0	1,530,853	0	1,530,853	65.01	
65.02	03620	GERIATRIC PSYCH	633,270	0	633,270	0	633,270	65.02	
66.00	06600	PHYSICAL THERAPY	2,243,134	0	2,243,134	0	2,243,134	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,378,795		1,378,795	0	1,378,795	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,274,146		2,274,146	0	2,274,146	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	10,457,810		10,457,810	0	10,457,810	73.00	
76.97	07697	CARDIAC REHABILITATION	560,404		560,404	0	560,404	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	808,778		808,778	0	808,778	90.00	
91.00	09100	EMERGENCY	3,325,293		3,325,293	0	3,325,293	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	450,632		450,632		450,632	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	47,485,202	0	47,485,202	0	47,485,202	200.00	
201.00		Less Observation Beds	450,632		450,632		450,632	201.00	
202.00		Total (see instructions)	47,034,570	0	47,034,570	0	47,034,570	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 11:45 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,981,547		2,981,547			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	427,936	48,632,788	49,060,724	0.158303	0.000000	50.00
51.00	05100	RECOVERY ROOM	47,856	1,082,510	1,130,366	0.392298	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	77,332	6,892,852	6,970,184	0.017199	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992,828	35,132,944	36,125,772	0.086586	0.000000	54.00
60.00	06000	LABORATORY	1,301,906	30,697,363	31,999,269	0.104735	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	30,018	3,754,977	3,784,995	0.497915	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,192,609	2,433,589	3,626,198	0.236268	0.000000	65.00
65.01	03610	SLEEP LAB	0	4,935,810	4,935,810	0.310152	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	209,065	209,065	3.029058	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	2,136,952	4,718,659	6,855,611	0.327197	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,552	4,463,114	4,520,666	0.304998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,939	5,873,785	5,944,724	0.382549	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,947,700	24,738,414	26,686,114	0.391882	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	662,644	662,644	0.845709	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,784	2,471,154	2,473,938	0.326919	0.000000	90.00
91.00	09100	EMERGENCY	161,953	9,104,114	9,266,067	0.358868	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,997	570,822	599,819	0.751280	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,458,909	186,374,604	197,833,513			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,458,909	186,374,604	197,833,513			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
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
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
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
76.97	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part II
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,090,814	49,060,724	0.022234	190,846	4,243
51.00	05100	RECOVERY ROOM	97,689	1,130,366	0.086422	25,295	2,186
53.00	05300	ANESTHESIOLOGY	19,263	6,970,184	0.002764	32,094	89
54.00	05400	RADIOLOGY-DIAGNOSTIC	430,513	36,125,772	0.011917	392,645	4,679
60.00	06000	LABORATORY	261,740	31,999,269	0.008180	430,106	3,518
64.00	06400	INTRAVENOUS THERAPY	212,565	3,784,995	0.056160	6,593	370
65.00	06500	RESPIRATORY THERAPY	64,729	3,626,198	0.017850	189,268	3,378
65.01	03610	SLEEP LAB	259,110	4,935,810	0.052496	0	0
65.02	03620	GERIATRIC PSYCH	82,628	209,065	0.395226	0	0
66.00	06600	PHYSICAL THERAPY	131,654	6,855,611	0.019204	138,408	2,658
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,390	4,520,666	0.007828	32,540	255
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,798	5,944,724	0.009386	490	5
73.00	07300	DRUGS CHARGED TO PATIENTS	323,242	26,686,114	0.012113	371,760	4,503
76.97	07697	CARDIAC REHABILITATION	122,036	662,644	0.184165	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	170,049	2,473,938	0.068736	2,310	159
91.00	09100	EMERGENCY	402,663	9,266,067	0.043456	6,101	265
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,978	599,819	0.116665	852	99
200.00		Total (lines 50 through 199)	3,829,861	194,851,966		1,819,308	26,407

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Title XVIII		Hospital		Cost	
			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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
76.97	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	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description			Title XVIII		Hospital	Cost	
			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	49,060,724	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	1,130,366	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	6,970,184	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,125,772	0.000000
60.00	06000	LABORATORY	0	0	0	31,999,269	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,784,995	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,626,198	0.000000
65.01	03610	SLEEP LAB	0	0	0	4,935,810	0.000000
65.02	03620	GERIATRIC PSYCH	0	0	0	209,065	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	6,855,611	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,520,666	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,944,724	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,686,114	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	662,644	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	2,473,938	0.000000
91.00	09100	EMERGENCY	0	0	0	9,266,067	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	599,819	0.000000
200.00		Total (lines 50 through 199)	0	0	0	194,851,966	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 11:45 am

				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	190,846	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	25,295	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.000000	32,094	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	392,645	0	0	0	54.00	
60.00	06000	LABORATORY	0.000000	430,106	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	6,593	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	189,268	0	0	0	65.00	
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01	
65.02	03620	GERIATRIC PSYCH	0.000000	0	0	0	0	65.02	
66.00	06600	PHYSICAL THERAPY	0.000000	138,408	0	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	32,540	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	490	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	371,760	0	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	2,310	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	6,101	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	852	0	0	0	92.00	
200.00		Total (lines 50 through 199)		1,819,308	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 11:45 am

				Title XVIII	Hospital	Cost
	Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
65.02	03620	GERIATRIC PSYCH	0	0		65.02
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/23/2021 11:45 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.158303	0	14,767,306	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.392298	0	454,137	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.017199	0	2,083,689	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086586	0	11,819,810	0	0	0	54.00
60.00	06000	LABORATORY	0.104735	0	9,682,715	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.497915	0	1,327,916	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.236268	0	756,765	0	0	0	65.00
65.01	03610	SLEEP LAB	0.310152	0	1,162,580	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	3.029058	0	130,035	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.327197	0	1,266,308	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.304998	0	1,801,774	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382549	0	2,304,181	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391882	0	8,698,619	1,783	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.845709	0	253,653	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.326919	0	1,097,105	0	0	0	90.00
91.00	09100	EMERGENCY	0.358868	0	2,533,620	2,064	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751280	0	382,123	0	0	0	92.00
200.00		Subtotal (see instructions)		0	60,522,336	3,847	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0			201.00
202.00		Net Charges (line 200 - line 201)		0	60,522,336	3,847	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/23/2021 11:45 am

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,337,709	0		50.00
51.00	05100	RECOVERY ROOM	178,157	0		51.00
53.00	05300	ANESTHESIOLOGY	35,837	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,023,430	0		54.00
60.00	06000	LABORATORY	1,014,119	0		60.00
64.00	06400	INTRAVENOUS THERAPY	661,189	0		64.00
65.00	06500	RESPIRATORY THERAPY	178,799	0		65.00
65.01	03610	SLEEP LAB	360,577	0		65.01
65.02	03620	GERIATRIC PSYCH	393,884	0		65.02
66.00	06600	PHYSICAL THERAPY	414,332	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	549,537	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	881,462	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,408,832	699		73.00
76.97	07697	CARDIAC REHABILITATION	214,517	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	358,664	0		90.00
91.00	09100	EMERGENCY	909,235	741		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287,081	0		92.00
200.00		Subtotal (see instructions)	13,207,361	1,440		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,207,361	1,440		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/23/2021 11:45 am
		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)		4,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,287	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)		963	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		2,561	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)		632	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		176	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)		51	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		575	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)		1,961	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)		572	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		178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,271,497	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)		31,432	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)		9,108	25.00
26.00	Total swing-bed cost (see instructions)		4,481,492	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,790,005	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)		1,790,005	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,390.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		799,733	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)		799,733	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/23/2021 11:45 am

		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					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)					372,401 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,172,134 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)					2,727,437 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					795,560 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					3,522,997 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)					324 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,390.84 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					450,632 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/23/2021 11:45 am

		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	973,891	6,271,497	0.155288	450,632	69,978	90.00
91.00	Nursing School cost	0	6,271,497	0.000000	450,632	0	91.00
92.00	Allied health cost	0	6,271,497	0.000000	450,632	0	92.00
93.00	All other Medical Education	0	6,271,497	0.000000	450,632	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/23/2021 11:45 am	
		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		514,050		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.158303	190,846	30,211	50.00
51.00	05100 RECOVERY ROOM	0.392298	25,295	9,923	51.00
53.00	05300 ANESTHESIOLOGY	0.017199	32,094	552	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086586	392,645	33,998	54.00
60.00	06000 LABORATORY	0.104735	430,106	45,047	60.00
64.00	06400 INTRAVENOUS THERAPY	0.497915	6,593	3,283	64.00
65.00	06500 RESPIRATORY THERAPY	0.236268	189,268	44,718	65.00
65.01	03610 SLEEP LAB	0.310152	0	0	65.01
65.02	03620 GERIATRIC PSYCH	3.029058	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.327197	138,408	45,287	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.304998	32,540	9,925	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382549	490	187	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.391882	371,760	145,686	73.00
76.97	07697 CARDIAC REHABILITATION	0.845709	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.326919	2,310	755	90.00
91.00	09100 EMERGENCY	0.358868	6,101	2,189	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751280	852	640	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,819,308	372,401	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)		1,819,308		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/23/2021 11:45 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.158303	6,069	961	50.00
51.00	05100 RECOVERY ROOM	0.392298	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.017199	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086586	232,256	20,110	54.00
60.00	06000 LABORATORY	0.104735	292,048	30,588	60.00
64.00	06400 INTRAVENOUS THERAPY	0.497915	4,378	2,180	64.00
65.00	06500 RESPIRATORY THERAPY	0.236268	481,189	113,690	65.00
65.01	03610 SLEEP LAB	0.310152	0	0	65.01
65.02	03620 GERIATRIC PSYCH	3.029058	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.327197	1,422,077	465,299	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.304998	7,628	2,327	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382549	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.391882	872,879	342,066	73.00
76.97	07697 CARDIAC REHABILITATION	0.845709	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.326919	474	155	90.00
91.00	09100 EMERGENCY	0.358868	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751280	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,318,998	977,376	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)		3,318,998		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/23/2021 11:45 am	
Cost Center Description		Title XIX	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.158303	0	0	50.00
51.00	05100 RECOVERY ROOM	0.392298	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.017199	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086586	0	0	54.00
60.00	06000 LABORATORY	0.104735	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.497915	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.236268	0	0	65.00
65.01	03610 SLEEP LAB	0.310152	0	0	65.01
65.02	03620 GERIATRIC PSYCH	3.029058	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.327197	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.304998	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382549	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.391882	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.845709	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.326919	0	0	90.00
91.00	09100 EMERGENCY	0.358868	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751280	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/23/2021 11:45 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			13,208,801
2.00	Medical and other services reimbursed under OPPS (see instructions)			0
3.00	OPPS payments			0
4.00	Outlier payment (see instructions)			0
4.01	Outlier reconciliation amount (see instructions)			0
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000
6.00	Line 2 times line 5			0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00
8.00	Transitional corridor payment (see instructions)			0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0
10.00	Organ acquisitions			0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			13,208,801
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0
14.00	Total reasonable charges (sum of lines 12 and 13)			0
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0
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
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000
18.00	Total customary charges (see instructions)			0
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0
21.00	Lesser of cost or charges (see instructions)			13,340,889
22.00	Interns and residents (see instructions)			0
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			100,696
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			10,380,047
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,860,146
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0
30.00	Subtotal (sum of lines 27 through 29)			2,860,146
31.00	Primary payer payments			387
32.00	Subtotal (line 30 minus line 31)			2,859,759
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0
34.00	Allowable bad debts (see instructions)			1,989,733
35.00	Adjusted reimbursable bad debts (see instructions)			1,293,326
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			857,303
37.00	Subtotal (see instructions)			4,153,085
38.00	MSP-LCC reconciliation amount from PS&R			0
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
39.97	Demonstration payment adjustment amount before sequestration			0
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0
40.00	Subtotal (see instructions)			4,153,085
40.01	Sequestration adjustment (see instructions)			6,645
40.02	Demonstration payment adjustment amount after sequestration			0
40.03	Sequestration adjustment-PARHM pass-throughs			0
41.00	Interim payments			3,133,357
41.01	Interim payments-PARHM			0
42.00	Tentative settlement (for contractors use only)			0
42.01	Tentative settlement-PARHM (for contractor use only)			0
43.00	Balance due provider/program (see instructions)			1,013,083
43.01	Balance due provider/program-PARHM (see instructions)			0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0
91.00	Outlier reconciliation adjustment amount (see instructions)			0
92.00	The rate used to calculate the Time Value of Money			0.00
93.00	Time Value of Money (see instructions)			0
94.00	Total (sum of lines 91 and 93)			0

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part B
Date/Time Prepared:
8/23/2021 11:45 am

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part I
Date/Time Prepared:
8/23/2021 11:45 am

		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		782,778		3,094,372	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0	06/03/2020	38,985	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		06/03/2020	4,010		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)		-4,010		38,985	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)		778,768		3,133,357	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		265,967		1,013,083	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,044,735		4,146,440	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: 14-1334

Period:

Worksheet E-1

Component CCN: 14-Z334

From 04/01/2020
To 03/31/2021Part I
Date/Time Prepared:
8/23/2021 11:45 am

		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		4,580,923		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51		06/03/2020	11,392		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)		-11,392		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)		4,569,531		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		99,922		0	6.02
7.00	Total Medicare program liability (see instructions)		4,469,609		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: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part II
Date/Time Prepared:
8/23/2021 11:45 am

		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
				Overrides
				1.00
	CONTRACTOR OVERRIDES			
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2020 To 03/31/2021	Worksheet E-2 Date/Time Prepared: 8/23/2021 11:45 am	
		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)		3,558,227	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)		987,150	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		2,533	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)		4,545,377	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		4,545,377	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)		4,545,377	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		68,602	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		4,476,775	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)		4,476,775	0	19.00
19.01	Sequestration adjustment (see instructions)		7,166	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)		1,579	0	19.25
20.00	Interim payments		4,569,531	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)		-101,501	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 - SWING BEDS		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet E-2
		Component CCN: 14-Z334		Date/Time Prepared: 8/23/2021 11:45 am
		Title XIX	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)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		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)			16.55
16.99	Demonstration payment adjustment amount before sequestration		0	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	19.25
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	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	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2020 To 03/31/2021	Worksheet E-3 Part V Date/Time Prepared: 8/23/2021 11:45 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,172,134	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)		1,172,134	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,183,855	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)		1,183,855	19.00
20.00	Deductibles (exclude professional component)		185,808	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		998,047	22.00
23.00	Coinsurance		352	23.00
24.00	Subtotal (line 22 minus line 23)		997,695	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		74,945	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		48,714	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,147	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,046,409	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)		1,046,409	30.00
30.01	Sequestration adjustment (see instructions)		1,674	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		778,768	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		265,967	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	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: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet G

Date/Time Prepared:
8/23/2021 11:45 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	4,927,108	0	49,849	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	33,954,545	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-23,384,624	0	0	0	6.00
7.00 Inventory	1,987,034	0	0	0	7.00
8.00 Prepaid expenses	99,394	0	0	0	8.00
9.00 Other current assets	180,930	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	17,764,387	0	49,849	0	11.00
FIXED ASSETS					
12.00 Land	179,386	0	0	0	12.00
13.00 Land improvements	1,204,416	0	0	0	13.00
14.00 Accumulated depreciation	-888,413	0	0	0	14.00
15.00 Buildings	32,933,271	0	0	0	15.00
16.00 Accumulated depreciation	-17,440,004	0	0	0	16.00
17.00 Leasehold improvements	2,333	0	0	0	17.00
18.00 Accumulated depreciation	-253	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	148,889	0	0	0	21.00
22.00 Accumulated depreciation	-128,498	0	0	0	22.00
23.00 Major movable equipment	17,186,927	0	0	0	23.00
24.00 Accumulated depreciation	-11,533,045	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	21,665,009	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	23,126	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	23,126	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	39,452,522	0	49,849	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,956,307	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	2,178,445	0	0	0	39.00
40.00 Notes and loans payable (short term)	223,595	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	8,248,358	0	0	0	43.00
44.00 Other current liabilities	1,010,077	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	13,616,782	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	14,200,715	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	269,229	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	14,469,944	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	28,086,726	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	11,365,796	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	49,849	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	11,365,796	0	49,849	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	39,452,522	0	49,849	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-1

Date/Time Prepared:
8/23/2021 11:45 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,191,040		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,825,141				2.00
3.00	Total (sum of line 1 and line 2)		11,365,899		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	RESTRICTED DONATIONS	0		0		10,094	6.00
7.00	RESTRICTED GRANTS	0		0		110,045	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,365,899		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	RESTRICTED PURCHASES	0		0		103,055	14.00
15.00		0		0		0	15.00
16.00	ROUNDING	103		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		103		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,365,796		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	32,765		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)	32,765		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	RESTRICTED DONATIONS		0				6.00
7.00	RESTRICTED GRANTS		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	120,139		0			10.00
11.00	Subtotal (line 3 plus line 10)	152,904		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	RESTRICTED PURCHASES		0				14.00
15.00			0				15.00
16.00	ROUNDING		0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	103,055		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	49,849		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
8/23/2021 11:45 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	935,581		935,581	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,617,660		1,617,660	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)	2,553,241		2,553,241	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,553,241		2,553,241	17.00
18.00	Ancillary services	8,445,580	193,410,419	201,855,999	18.00
19.00	Outpatient services	0	0	0	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,998,821	193,410,419	204,409,240	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,072,110		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)		47,072,110		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-3

Date/Time Prepared:
8/23/2021 11:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	204,409,240	1.00
2.00	Less contractual allowances and discounts on patients' accounts	130,945,840	2.00
3.00	Net patient revenues (line 1 minus line 2)	73,463,400	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,072,110	4.00
5.00	Net income from service to patients (line 3 minus line 4)	26,391,290	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	75,473	6.00
7.00	Income from investments	688,765	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	3,093	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	123,294	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	7	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	7,617	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	35,037	22.00
23.00	Governmental appropriations	11,659	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	4,568,405	24.50
25.00	Total other income (sum of lines 6-24)	5,513,350	25.00
26.00	Total (line 5 plus line 25)	31,904,640	26.00
27.00	CONTR TO AFFILIATES, LOSS ON EQUIP	36,729,781	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	36,729,781	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,825,141	29.00