

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
11/24/2021 8:15 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/24/2021	Time: 8:15 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 ST. JOSEPHS HOSPITAL-HIGHLAND IL (14-1336) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ 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	-586,777	-1,178,349	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	-762,783	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-1,349,560	-1,178,349	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: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 8:15 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 12866 TROXLER AVENUE			PO Box:				1.00		
2.00	City: HIGHLAND			State: IL		Zip Code: 62249		County: MADISON 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ST. JOSEPHS HOSPITAL-HIGHLAND IL	141336	41180	1	06/01/2004	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ST. JOSEPHS HOSPITAL-SWING BED	14Z336	41180		08/19/2004	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		
21.00	Type of Control (see instructions)						1			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 8:15 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	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.					1		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.					1		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. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 8:15 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/24/2021 8:15 am

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
				1.00			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				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.	0				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	58,897		0		284,232118.01	
				1.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.06		122.00	
				Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 8:15 am	
		1.00			2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H005		140.00	
		1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131		141.00	
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00	
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62794		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 8:15 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/24/2021 8:15 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/27/2021	Y	09/27/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/24/2021 8:15 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		Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y	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.		Y	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.		Y	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.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/24/2021 8:15 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.	MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 8:15 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	56,670.25	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	56,670.25	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	56,670.25	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				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: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 8:15 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)	1,135	22	2,393		1.00
2.00	HMO and other (see instructions)	709	125			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	2,560	0	3,915		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	252		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,695	22	6,560		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)	3,695	22	6,560	0.00	252.86
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			37		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC					25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	26.25
28.00	Observation Bed Days		8	544		27.00
29.00	Ambulance Trips	0				28.00
30.00	Employee discount days (see instruction)			15		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 8:15 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	328	6	676	1.00
2.00 HMO and other (see instructions)			174	36		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	328	6	676	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: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/24/2021 8:15 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)			0.256080 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	4,171,461		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	18,302,585		6.00
7.00	Medicaid cost (line 1 times line 6)	4,686,926		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)	515,465		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	515,465		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,127,145	619,165	1,746,310 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	288,639	619,165	907,804 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	288,639	619,165	907,804 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,535,796		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	678,182		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,043,357		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,492,439		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	747,359		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,655,163		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,170,628		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,101,464	2,101,464	830,858	2,932,322	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	838,037	838,037	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	620	3,261,822	3,262,442	0	3,262,442	4.00
5.01	01160	COMMUNICATIONS	0	7,508	7,508	2,499	10,007	5.01
5.02	00550	DATA PROCESSING	0	1,168,097	1,168,097	-75	1,168,022	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	120,730	113,606	234,336	-8,519	225,817	5.03
5.04	00570	ADMITTING	0	282	282	100	382	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,095,319	2,095,319	0	2,095,319	5.05
5.06	00590	OTHER ADMIN & GENERAL	546,674	7,173,790	7,720,464	-86,323	7,634,141	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	157	157	-157	0	6.00
7.00	00700	OPERATION OF PLANT	235,139	862,031	1,097,170	-420	1,096,750	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,108	136,108	0	136,108	8.00
9.00	00900	HOUSEKEEPING	238,387	171,901	410,288	0	410,288	9.00
10.00	01000	DIETARY	245,191	410,375	655,566	0	655,566	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	466,574	70,991	537,565	2,867	540,432	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	185,449	7,821	193,270	0	193,270	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,037,162	1,318,116	3,355,278	-162,677	3,192,601	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	924,569	1,799,492	2,724,061	-1,126,504	1,597,557	50.00
53.00	05300	ANESTHESIOLOGY	0	723,223	723,223	-15,257	707,966	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	772,548	694,455	1,467,003	-156,358	1,310,645	54.00
60.00	06000	LABORATORY	663,598	1,251,790	1,915,388	-583,982	1,331,406	60.00
65.00	06500	RESPIRATORY THERAPY	124,311	68,242	192,553	-36,680	155,873	65.00
65.01	06501	SLEEP LAB	55,494	8,811	64,305	-4,652	59,653	65.01
66.00	06600	PHYSICAL THERAPY	865,529	20,146	885,675	-21,924	863,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,220	554	192,774	17,865	210,639	67.00
68.00	06800	SPEECH PATHOLOGY	29,508	382	29,890	3,482	33,372	68.00
68.01	03040	AUDIOLOGY	45,103	88,931	134,034	-88,079	45,955	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	108,476	44,096	152,572	2,258,959	2,411,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	439,289	439,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	578,935	1,532,660	2,111,595	21,542	2,133,137	73.00
76.97	07697	CARDIAC REHABILITATION	134,965	4,927	139,892	-1,266	138,626	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	175,311	855,259	1,030,570	-366,058	664,512	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	127,264	0	127,264	0	127,264	90.00
91.00	09100	EMERGENCY	828,622	1,233,199	2,061,821	-135,807	1,926,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	147,686	31,740	179,426	1,405	180,831	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,621,844	1,621,844	-1,621,844	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,850,065	28,879,139	38,729,204	321	38,729,525	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	11,879	11,879	0	11,879	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,750	34,960	36,710	-19	36,691	192.00
194.00	07950	TRANSPORTATION	16,987	5,941	22,928	-302	22,626	194.00
194.01	07951	FUND DEVELOPMENT	64,455	-59,135	5,320	0	5,320	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	9,933,257	28,872,784	38,806,041	0	38,806,041	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 8:15 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	281,405	3,213,727	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-273,382	564,655	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-288,910	2,973,532	4.00
5.01	01160	COMMUNICATIONS	0	10,007	5.01
5.02	00550	DATA PROCESSING	1,180,878	2,348,900	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-66,222	159,595	5.03
5.04	00570	ADMITTING	229,679	230,061	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-1,672,782	422,537	5.05
5.06	00590	OTHER ADMIN & GENERAL	-4,421,897	3,212,244	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-31,229	1,065,521	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-54,405	81,703	8.00
9.00	00900	HOUSEKEEPING	-32,412	377,876	9.00
10.00	01000	DIETARY	-57,720	597,846	10.00
11.00	01100	CAFETERIA	-53,710	-53,710	11.00
13.00	01300	NURSING ADMINISTRATION	0	540,432	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	416,508	416,508	16.00
17.00	01700	SOCIAL SERVICE	0	193,270	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,040,587	2,152,014	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-358,616	1,238,941	50.00
53.00	05300	ANESTHESIOLOGY	-685,210	22,756	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,310,645	54.00
60.00	06000	LABORATORY	-36,709	1,294,697	60.00
65.00	06500	RESPIRATORY THERAPY	-26,324	129,549	65.00
65.01	06501	SLEEP LAB	0	59,653	65.01
66.00	06600	PHYSICAL THERAPY	-40	863,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	210,639	67.00
68.00	06800	SPEECH PATHOLOGY	0	33,372	68.00
68.01	03040	AUDIOLOGY	-407	45,548	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,411,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	439,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-43,452	2,089,685	73.00
76.97	07697	CARDIAC REHABILITATION	0	138,626	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	664,512	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	127,264	90.00
91.00	09100	EMERGENCY	-468,775	1,457,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	180,831	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,504,319	31,225,206	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	11,879	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	36,691	192.00
194.00	07950	TRANSPORTATION	0	22,626	194.00
194.01	07951	FUND DEVELOPMENT	0	5,320	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,504,319	31,301,722	200.00

RECLASSIFICATIONS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/24/2021 8:15 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - TELEPHONE					
1.00	COMMUNICATIONS	5.01	0	2,499		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
	0		0	2,499		
	C - POSTAGE					
1.00	OTHER ADMIN & GENERAL	5.06	0	9,849		1.00
	0		0	9,849		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,621,844		1.00
	0		0	1,621,844		
	E - MED SUPPLIES - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	2,255,833		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	439,289		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	0		0	2,695,122		
	F - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	50,151		1.00
2.00	LABORATORY	60.00	0	20		2.00
3.00	PHYSICAL THERAPY	66.00	0	222		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	50,393		
	G - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,842		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,209		2.00
	0		0	47,051		
	I - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	826,828		1.00
	0		0	826,828		
	K - REHAB ADMIN					
1.00	OCCUPATIONAL THERAPY	67.00	16,411	859		1.00
2.00	SPEECH PATHOLOGY	68.00	1,781	93		2.00
	0		18,192	952		
	L - HEALTH CRISIS RECLASS					
1.00	PURCHASING RECEIVING AND STORES	5.03	1,330	0		1.00
2.00	ADMITTING	5.04	100	0		2.00
3.00	NURSING ADMINISTRATION	13.00	2,867	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	14,497	0		4.00
5.00	OPERATING ROOM	50.00	7,572	0		5.00
6.00	LABORATORY	60.00	664	0		6.00
7.00	RESPIRATORY THERAPY	65.00	560	0		7.00
8.00	PHYSICAL THERAPY	66.00	3,411	0		8.00
9.00	SPEECH PATHOLOGY	68.00	1,446	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	145	2,981		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	3,446	0		11.00
12.00	HYPERBARIC OXYGEN THERAPY	76.98	6,409	0		12.00
13.00	EMERGENCY	91.00	430	0		13.00
14.00	O/P GERIATRIC PSYCH CENTER	93.00	1,718	0		14.00
	0		44,595	2,981		
	M - TO RECLASS PLANT OPERATIONS COSTS					
1.00	OPERATION OF PLANT	7.00	0	157		1.00
	TOTALS		0	157		

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6
Date/Time Prepared:
11/24/2021 8:15 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	N - OCCUPATIONAL THERAPY					1.00
	OCCUPATIONAL THERAPY	67.00	0	786		
	TOTALS		0	786		
1.00	O - SPEECH THERAPY					1.00
	SPEECH PATHOLOGY	68.00	0	162		
	TOTALS		0	162		
500.00	Grand Total: Increases		62,787	5,258,624	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/24/2021 8:15 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - TELEPHONE						
1.00	DATA PROCESSING	5.02	0	75	0		1.00
2.00	OTHER ADMIN & GENERAL	5.06	0	1,545	0		2.00
3.00	OPERATION OF PLANT	7.00	0	577	0		3.00
4.00	TRANSPORTATION	194.00	0	302	0		4.00
	0		0	2,499			
	C - POSTAGE						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	9,849	0		1.00
	0		0	9,849			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,621,844	11		1.00
	0		0	1,621,844			
	E - MED SUPPLIES - IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	176,185	0		1.00
2.00	OPERATING ROOM	50.00	0	1,120,043	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	15,257	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	125,387	0		4.00
5.00	LABORATORY	60.00	0	584,666	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	37,240	0		6.00
7.00	SLEEP LAB	65.01	0	4,652	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	6,413	0		8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	29	0		9.00
10.00	AUDIOLOGY	68.01	0	87,293	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	32,055	0		11.00
12.00	CARDIAC REHABILITATION	76.97	0	1,266	0		12.00
13.00	HYPERBARIC OXYGEN THERAPY	76.98	0	369,540	0		13.00
14.00	EMERGENCY	91.00	0	134,764	0		14.00
15.00	O/P GERIATRIC PSYCH CENTER	93.00	0	313	0		15.00
16.00	PHYSICIANS PRIVATE OFFICES	192.00	0	19	0		16.00
	0		0	2,695,122			
	F - DRUGS CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	989	0		1.00
2.00	OPERATING ROOM	50.00	0	14,033	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,971	0		3.00
4.00	HYPERBARIC OXYGEN THERAPY	76.98	0	2,927	0		4.00
5.00	EMERGENCY	91.00	0	1,473	0		5.00
	0		0	50,393			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	47,051	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	47,051			
	I - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	826,828	9		1.00
	0		0	826,828			
	K - REHAB ADMIN						
1.00	PHYSICAL THERAPY	66.00	18,192	952	0		1.00
2.00		0.00	0	0	0		2.00
	0		18,192	952			
	L - HEALTH CRISIS RECLASS						
1.00	OTHER ADMIN & GENERAL	5.06	44,595	2,981	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
	0		44,595	2,981			
	M - TO RECLASS PLANT OPERATIONS COSTS						
1.00	MAINTENANCE & REPAIRS	6.00	0	157	0		1.00
	TOTALS		0	157			
	N - OCCUPATIONAL THERAPY						
1.00	AUDIOLOGY	68.01	0	786	0		1.00
	TOTALS		0	786			

RECLASSIFICATIONS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/24/2021 8:15 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	0 - SPEECH THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	162	0	1.00
	TOTALS		0	162		
500.00	Grand Total: Decreases			62,787	5,258,624	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/24/2021 8:15 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,052,874	0	0	0	0	1.00
2.00	Land Improvements	1,469,318	0	0	0	0	2.00
3.00	Buildings and Fixtures	39,879,603	0	0	0	37,964	3.00
4.00	Building Improvements	21,000	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,303,886	0	0	0	1,315,309	6.00
7.00	HIT designated Assets	9,193,721	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,920,402	0	0	0	1,353,273	8.00
9.00	Reconciling Items	7,827,251	0	0	0	601,692	9.00
10.00	Total (line 8 minus line 9)	57,093,151	0	0	0	751,581	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,052,874	0				1.00
2.00	Land Improvements	1,469,318	0				2.00
3.00	Buildings and Fixtures	39,841,639	0				3.00
4.00	Building Improvements	21,000	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	10,988,577	0				6.00
7.00	HIT designated Assets	9,193,721	0				7.00
8.00	Subtotal (sum of lines 1-7)	63,567,129	0				8.00
9.00	Reconciling Items	7,225,559	0				9.00
10.00	Total (line 8 minus line 9)	56,341,570	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/24/2021 8:15 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	2,101,464	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,101,464	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,101,464				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,101,464				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/24/2021 8:15 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	43,384,831	0	43,384,831	0.682504	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,182,298	0	20,182,298	0.317496	0	2.00
3.00	Total (sum of lines 1-2)	63,567,129	0	63,567,129	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed 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	1,932,578	-376,537	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	553,446	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,486,024	-376,537	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	1,621,844	35,842	0	0	3,213,727	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,209	0	0	564,655	2.00
3.00	Total (sum of lines 1-2)	1,621,844	47,051	0	0	3,778,382	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-376,537	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-1,925,016			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	-219,154			0	12.00
13.00	Laundry and linen service	B	-917	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-53,710	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	-693	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/24/2021 8:15 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			
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-274,096	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-66,222	PURCHASING RECEIVING AND STORES	5.03	0	33.00
33.01	MISCELLANEOUS INCOME	B	-31,689	OTHER ADMIN & GENERAL	5.06	0	33.01
33.02	MISCELLANEOUS INCOME	B	-23,135	OPERATION OF PLANT	7.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-32,412	HOUSEKEEPING	9.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-275	OPERATING ROOM	50.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-5,720	LABORATORY	60.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-40	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-407	AUDIOLOGY	68.01	0	33.07
33.08	ADVERTISING EXPENSES	A	-710	OTHER ADMIN & GENERAL	5.06	0	33.08
33.09	MEDICAID TAX ASSESSMENT	A	-1,258,413	OTHER ADMIN & GENERAL	5.06	0	33.09
33.10	CRNA-CONTRACT LABOR	A	-685,210	ANESTHESIOLOGY	53.00	0	33.10
33.11	PENSION ADJUSTMENT	A	1,154,553	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	HSMS MED GROUP ADMIN	A	-2,806,850	OTHER ADMIN & GENERAL	5.06	0	33.12
33.13	USEFUL LIVES CARRYFORWARD ADJUSTMEN	A	111,756	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	LOBBYING EXPENSE	A	-15,960	OTHER ADMIN & GENERAL	5.06	0	33.14
33.15	COMMUNITY RELATIONS BENEFITS	A	-1,548	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	COMMUNITY RELATIONS SALARY	A	-4,905	OTHER ADMIN & GENERAL	5.06	0	33.16
33.17	COMMUNITY RELATIONS OTHER EXPENSE	A	-4,669	OTHER ADMIN & GENERAL	5.06	0	33.17
33.18	SELF-INSURANCE ADJUSTMENT	A	-1,281,985	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	PROPERTY TAX NOT RELATED TO PATIENT	A	-8,094	OPERATION OF PLANT	7.00	0	33.19
33.20	BUILDING RELIFING	A	546,186	CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	EQUIPMENT RELIFING	A	714	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.21
33.22	MARKETING BENEFITS	A	-10,313	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	MARKETING SALARIES	A	-32,688	OTHER ADMIN & GENERAL	5.06	0	33.23
33.24	MARKETING OTHER EXPENSE	A	-90,489	OTHER ADMIN & GENERAL	5.06	0	33.24
33.25	ALCOHOL	A	-2,991	OTHER ADMIN & GENERAL	5.06	0	33.25
33.26	ATHLETICARE BENEFITS	A	-130	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	ATHLETICARE SALARIES	A	-411	OTHER ADMIN & GENERAL	5.06	0	33.27
33.28	ATHLETICARE OTHER EXPENSE	A	-44,314	OTHER ADMIN & GENERAL	5.06	0	33.28
33.29	IRS LATE FEE	A	-105	OTHER ADMIN & GENERAL	5.06	0	33.29
33.30	MEALS ON WHEEL REVENUE	B	-57,720	DIETARY	10.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,504,319				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: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/24/2021 8:15 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	2,439,137	2,442,926	1.00
2.00	5.02	DATA PROCESSING	CONTRACTED SERVICES - ISC	2,334,355	1,153,477	2.00
3.00	5.05	CASHIERING/ACCOUNTS RECEIVAB	SBO FEE	420,402	2,093,184	3.00
4.00	5.04	ADMITTING	SBO FEE	229,679	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SBO FEE	417,201	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HR FEE	65,070	210,768	4.02
4.03	5.06	OTHER ADMIN & GENERAL	CONTRACTED SERVICES - SSC	986,568	982,550	4.03
4.04	5.06	OTHER ADMIN & GENERAL	PURCHASED SERVICES	0	74,426	4.04
4.05	5.06	OTHER ADMIN & GENERAL	IL - A&G	252,170	304,209	4.05
4.06	13.00	NURSING ADMINISTRATION	IL - FLOAT POOL	82,450	82,450	4.06
4.07	60.00	LABORATORY	IL - LAB	732	732	4.07
4.08	73.00	DRUGS CHARGED TO PATIENTS	IL - SHARED PHARMACIST	45,384	88,836	4.08
4.09	8.00	LAUNDRY & LINEN SERVICE	IL - LAUNDRY	50,224	103,712	4.09
4.10	5.06	OTHER ADMIN & GENERAL	IL - LIBRARY	11,216	16,472	4.10
4.11	0.00			0	0	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,334,588	7,553,742	5.00

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

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

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

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

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

6.00	B	HSBS	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/24/2021 8:15 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	-3,789	0		1.00
2.00	1,180,878	0		2.00
3.00	-1,672,782	0		3.00
4.00	229,679	0		4.00
4.01	417,201	0		4.01
4.02	-145,698	0		4.02
4.03	4,018	0		4.03
4.04	-74,426	0		4.04
4.05	-52,039	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	-43,452	0		4.08
4.09	-53,488	0		4.09
4.10	-5,256	0		4.10
4.11	0	0		4.11
5.00	-219,154			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/24/2021 8:15 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	30.00	ADULTS & PEDIATRICS	1,040,587	1,040,587	0	0	0	1.00
2.00	91.00	EMERGENCY	968,013	468,775	499,238	0	0	2.00
3.00	91.00	EMERGENCY	96,000	0	96,000	0	0	3.00
4.00	76.98	HYPERBARIC OXYGEN THERAPY	25,000	0	25,000	0	0	4.00
5.00	50.00	OPERATING ROOM	9,963	0	9,963	0	0	5.00
6.00	50.00	OPERATING ROOM	358,341	358,341	0	0	0	6.00
7.00	93.00	O/P GERIATRIC PSYCH CENTER	28,700	0	28,700	0	0	7.00
8.00	60.00	LABORATORY	88,539	30,989	57,550	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	26,961	26,324	637	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	1,500	0	1,500	0	0	10.00
200.00			2,643,604	1,925,016	718,588		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	93.00	O/P GERIATRIC PSYCH CENTER	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,040,587		1.00
2.00	91.00	EMERGENCY	0	0	0	468,775		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	0		5.00
6.00	50.00	OPERATING ROOM	0	0	0	358,341		6.00
7.00	93.00	O/P GERIATRIC PSYCH CENTER	0	0	0	0		7.00
8.00	60.00	LABORATORY	0	0	0	30,989		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	26,324		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0		10.00
200.00			0	0	0	1,925,016		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2021 8:15 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					2	1.00
2.00	Line 1 multiplied by 15 hours per week					30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	22.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.16	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.08	41.08	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,808	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,808	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,808	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					82.18	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					2,465	22.00
23.00	Total salary equivalency (see instructions)					2,465	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2021 8:15 am		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.16	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						2,465	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						2,465	63.00
64.00	Total cost of outside supplier services (from your records)						894	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2021 8:15 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.95	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.48	39.48	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					217	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					217	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					217	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					78.91	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					1,184	22.00
23.00	Total salary equivalency (see instructions)					1,184	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2021 8:15 am	
				Speech Pathology		Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.95	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					1,184	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					1,184	63.00
64.00	Total cost of outside supplier services (from your records)					161	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATION S	
				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	3,213,727	3,213,727				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	564,655		564,655			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,973,532	20,553	660	2,994,745		4.00
5.01	01160	COMMUNICATIONS	10,007	2,946	9,970	0	22,923	5.01
5.02	00550	DATA PROCESSING	2,348,900	52,426	112,814	0	1,487	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	159,595	94,956	1,593	36,802	434	5.03
5.04	00570	ADMITTING	230,061	30,218	531	30	805	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	422,537	45,012	683	0	372	5.05
5.06	00590	OTHER ADMIN & GENERAL	3,212,244	255,741	10,631	151,380	4,150	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,065,521	168,497	3,775	70,896	496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,703	3,310	0	0	0	8.00
9.00	00900	HOUSEKEEPING	377,876	67,981	1,629	71,875	496	9.00
10.00	01000	DIETARY	597,846	87,178	1,823	73,927	434	10.00
11.00	01100	CAFETERIA	-53,710	80,294	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	540,432	24,558	19,402	141,539	124	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	416,508	39,981	185	0	991	16.00
17.00	01700	SOCIAL SERVICE	193,270	10,194	0	55,914	62	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,152,014	582,707	32,686	618,581	3,779	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,238,941	379,127	218,253	281,046	2,354	50.00
53.00	05300	ANESTHESIOLOGY	22,756	0	1,615	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,310,645	270,403	56,433	232,928	1,115	54.00
60.00	06000	LABORATORY	1,294,697	104,024	11,830	200,279	1,053	60.00
65.00	06500	RESPIRATORY THERAPY	129,549	68,875	7,667	37,649	0	65.00
65.01	06501	SLEEP LAB	59,653	0	755	16,732	681	65.01
66.00	06600	PHYSICAL THERAPY	863,711	152,478	3,561	256,506	1,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,639	32,203	409	62,903	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,372	0	413	9,870	0	68.00
68.01	03040	AUDIOLOGY	45,548	18,667	1,255	13,599	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,411,531	56,033	1,824	32,750	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	439,289	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,089,685	39,021	691	175,591	558	73.00
76.97	07697	CARDIAC REHABILITATION	138,626	49,910	5,611	40,693	310	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	664,512	114,053	1,472	54,790	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	127,264	0	0	38,371	0	90.00
91.00	09100	EMERGENCY	1,457,239	238,862	34,270	249,964	1,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	180,831	82,015	11,877	45,046	496	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,225,206	3,172,223	554,318	2,969,661	22,923	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	11,879	25,849	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	36,691	0	1,669	528	0	192.00
194.00	07950	TRANSPORTATION	22,626	0	8,668	5,122	0	194.00
194.01	07951	FUND DEVELOPMENT	5,320	15,655	0	19,434	0	194.01
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)	31,301,722	3,213,727	564,655	2,994,745	22,923	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	2,515,627					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	174,647	468,027				5.03
5.04	00570	ADMITTING	98,790	392	360,827			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	22,933	0	0	491,537		5.05
5.06	00590	OTHER ADMIN & GENERAL	1,341,610	146,387	0	0	5,122,143	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	54	0	0	54	6.00
7.00	00700	OPERATION OF PLANT	28,226	92,757	0	0	1,430,168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	85,013	8.00
9.00	00900	HOUSEKEEPING	12,349	31,224	0	0	563,430	9.00
10.00	01000	DIETARY	1,764	466	0	0	763,438	10.00
11.00	01100	CAFETERIA	0	0	0	0	26,584	11.00
13.00	01300	NURSING ADMINISTRATION	2,646	4,932	0	0	733,633	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	82,913	0	0	0	540,578	16.00
17.00	01700	SOCIAL SERVICE	19,405	1	0	0	278,846	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	140,247	28,089	86,277	23,971	3,668,351	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,036	30,573	9,501	37,571	2,264,402	50.00
53.00	05300	ANESTHESIOLOGY	0	7,809	3,524	8,387	44,091	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,390	35,637	39,160	138,799	2,149,510	54.00
60.00	06000	LABORATORY	57,334	45,698	82,532	102,623	1,900,070	60.00
65.00	06500	RESPIRATORY THERAPY	7,939	1,563	39,421	18,118	310,781	65.00
65.01	06501	SLEEP LAB	0	441	94	3,050	81,406	65.01
66.00	06600	PHYSICAL THERAPY	76,739	9,604	17,553	18,243	1,399,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,174	0	7,824	3,446	323,598	67.00
68.00	06800	SPEECH PATHOLOGY	3,528	0	604	353	48,140	68.00
68.01	03040	AUDIOLOGY	7,939	0	0	586	87,594	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	882	2,910	16,108	9,023	2,531,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,009	5,790	447,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,139	3,258	47,070	58,509	2,525,522	73.00
76.97	07697	CARDIAC REHABILITATION	40,575	1,143	0	1,543	278,411	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	45,867	2,333	1,026	14,259	898,312	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	2	1,952	167,589	90.00
91.00	09100	EMERGENCY	57,334	16,086	8,122	43,525	2,106,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	43,221	1,821	0	1,789	367,096	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,515,627	463,178	360,827	491,537	31,143,432	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	4,625	0	0	42,353	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	220	0	0	39,108	192.00
194.00	07950	TRANSPORTATION	0	4	0	0	36,420	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	40,409	194.01
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)	2,515,627	468,027	360,827	491,537	31,301,722	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

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Cost Center Description			OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	5,122,143					5.06
6.00	00600	MAINTENANCE & REPAIRS	11	65				6.00
7.00	00700	OPERATION OF PLANT	279,818	0	1,709,986			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,633	0	2,225	103,871		8.00
9.00	00900	HOUSEKEEPING	110,237	3	45,706	0	719,376	9.00
10.00	01000	DIETARY	149,370	9	58,612	81	12,542	10.00
11.00	01100	CAFETERIA	5,201	0	53,984	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	143,538	1	16,511	0	59	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	105,766	0	26,881	0	6,799	16.00
17.00	01700	SOCIAL SERVICE	54,557	0	6,854	0	117	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	717,733	19	391,770	57,530	263,214	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	443,039	8	254,898	11,709	74,259	50.00
53.00	05300	ANESTHESIOLOGY	8,627	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	420,560	3	181,800	9,356	55,621	54.00
60.00	06000	LABORATORY	371,756	3	69,938	0	19,576	60.00
65.00	06500	RESPIRATORY THERAPY	60,806	0	46,307	480	11,605	65.00
65.01	06501	SLEEP LAB	15,927	3	0	88	0	65.01
66.00	06600	PHYSICAL THERAPY	273,880	3	102,515	6,508	49,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,313	0	21,651	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,419	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	17,138	0	12,550	0	59	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	495,212	1	37,673	0	6,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,475	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	494,128	2	26,235	0	3,282	73.00
76.97	07697	CARDIAC REHABILITATION	54,472	2	33,556	0	7,619	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	175,758	1	76,681	2,465	27,957	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	32,789	0	0	0	0	90.00
91.00	09100	EMERGENCY	412,185	5	160,594	15,651	71,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	71,824	0	55,141	3	15,121	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,091,172	63	1,682,082	103,871	626,596	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	8,287	0	17,379	0	821	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	7,652	2	0	0	91,959	192.00
194.00	07950	TRANSPORTATION	7,126	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	7,906	0	10,525	0	0	194.01
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)	5,122,143	65	1,709,986	103,871	719,376	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	984,052					10.00
11.00	01100	CAFETERIA	406,046	491,815				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,511	914,253			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	680,024		16.00
17.00	01700	SOCIAL SERVICE	0	7,385	39,653	0	387,412	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	505,531	170,718	488,774	436,885	326,232	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,240	55,616	172,520	56,985	40,787	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,170	0	32,292	0	54.00
60.00	06000	LABORATORY	0	40,719	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,418	0	0	0	65.00
65.01	06501	SLEEP LAB	0	3,819	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	31,892	0	22,794	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,778	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,088	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	1,239	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,661	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	12,519	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	4,249	16,036	9,498	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	8,017	38,477	1,900	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	10,420	26,503	0	0	90.00
91.00	09100	EMERGENCY	51,235	40,744	108,180	113,971	20,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	4,856	24,110	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	984,052	487,819	914,253	674,325	387,412	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	5,699	0	192.00
194.00	07950	TRANSPORTATION	0	1,467	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	2,529	0	0	0	194.01
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)	984,052	491,815	914,253	680,024	387,412	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	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	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,026,757	0	7,026,757	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,395,463	0	3,395,463	50.00
53.00	05300	ANESTHESIOLOGY	0	52,718	0	52,718	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,894,312	0	2,894,312	54.00
60.00	06000	LABORATORY	0	2,402,062	0	2,402,062	60.00
65.00	06500	RESPIRATORY THERAPY	0	442,397	0	442,397	65.00
65.01	06501	SLEEP LAB	0	101,243	0	101,243	65.01
66.00	06600	PHYSICAL THERAPY	0	1,887,406	0	1,887,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	415,340	0	415,340	67.00
68.00	06800	SPEECH PATHOLOGY	0	58,647	0	58,647	68.00
68.01	03040	AUDIOLOGY	0	118,580	0	118,580	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	3,080,407	0	3,080,407	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	534,563	0	534,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,061,688	0	3,061,688	73.00
76.97	07697	CARDIAC REHABILITATION	0	403,843	0	403,843	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,229,568	0	1,229,568	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	237,301	0	237,301	90.00
91.00	09100	EMERGENCY	0	3,101,634	0	3,101,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	538,151	0	538,151	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	30,982,080	0	30,982,080	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	68,840	0	68,840	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	144,420	0	144,420	192.00
194.00	07950	TRANSPORTATION	0	45,013	0	45,013	194.00
194.01	07951	FUND DEVELOPMENT	0	61,369	0	61,369	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	31,301,722	0	31,301,722	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	20,553	660	21,213	4.00
5.01	01160	COMMUNICATIONS	0	2,946	9,970	12,916	5.01
5.02	00550	DATA PROCESSING	0	52,426	112,814	165,240	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	71,648	94,956	1,593	168,197	5.03
5.04	00570	ADMITTING	0	30,218	531	30,749	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	45,012	683	45,695	5.05
5.06	00590	OTHER ADMIN & GENERAL	915,842	255,741	10,631	1,182,214	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	168,497	3,775	172,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,310	0	3,310	8.00
9.00	00900	HOUSEKEEPING	0	67,981	1,629	69,610	9.00
10.00	01000	DIETARY	0	87,178	1,823	89,001	10.00
11.00	01100	CAFETERIA	0	80,294	0	80,294	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,558	19,402	43,960	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,981	185	40,166	16.00
17.00	01700	SOCIAL SERVICE	0	10,194	0	10,194	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,508	582,707	32,686	639,901	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	89,250	379,127	218,253	686,630	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,615	1,615	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,739	270,403	56,433	342,575	54.00
60.00	06000	LABORATORY	2,783	104,024	11,830	118,637	60.00
65.00	06500	RESPIRATORY THERAPY	966	68,875	7,667	77,508	65.00
65.01	06501	SLEEP LAB	1,308	0	755	2,063	65.01
66.00	06600	PHYSICAL THERAPY	7	152,478	3,561	156,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	32,203	409	32,612	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	413	413	68.00
68.01	03040	AUDIOLOGY	0	18,667	1,255	19,922	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	56,033	1,824	57,857	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,176	39,021	691	112,888	73.00
76.97	07697	CARDIAC REHABILITATION	0	49,910	5,611	55,521	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	114,053	1,472	115,525	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	272	90.00
91.00	09100	EMERGENCY	0	238,862	34,270	273,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	82,015	11,877	93,892	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,195,227	3,172,223	554,318	4,921,768	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	25,849	0	25,849	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,669	1,669	192.00
194.00	07950	TRANSPORTATION	0	0	8,668	8,668	194.00
194.01	07951	FUND DEVELOPMENT	0	15,655	0	15,655	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,195,227	3,213,727	564,655	4,973,609	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			COMMUNICATION S	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	12,916					5.01
5.02	00550	DATA PROCESSING	838	166,078				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	244	11,530	180,232			5.03
5.04	00570	ADMITTING	454	6,522	151	37,876		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	209	1,514	0	0	47,418	5.05
5.06	00590	OTHER ADMIN & GENERAL	2,340	88,572	56,371	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	21	0	0	6.00
7.00	00700	OPERATION OF PLANT	279	1,863	35,720	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	279	815	12,024	0	0	9.00
10.00	01000	DIETARY	244	116	179	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	70	175	1,899	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	559	5,474	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	35	1,281	1	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,129	9,259	10,817	9,062	2,313	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,327	4,426	11,773	997	3,625	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3,007	370	809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	628	4,251	13,723	4,110	13,385	54.00
60.00	06000	LABORATORY	593	3,785	17,598	8,662	9,901	60.00
65.00	06500	RESPIRATORY THERAPY	0	524	602	4,137	1,748	65.00
65.01	06501	SLEEP LAB	384	0	170	10	294	65.01
66.00	06600	PHYSICAL THERAPY	803	5,066	3,699	1,842	1,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	408	0	821	332	67.00
68.00	06800	SPEECH PATHOLOGY	0	233	0	63	34	68.00
68.01	03040	AUDIOLOGY	0	524	0	0	57	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	58	1,121	1,691	871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	211	559	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	314	7,337	1,254	4,940	5,645	73.00
76.97	07697	CARDIAC REHABILITATION	175	2,679	440	0	149	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,028	898	108	1,376	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	188	90.00
91.00	09100	EMERGENCY	733	3,785	6,195	852	4,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	279	2,853	701	0	173	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,916	166,078	178,364	37,876	47,418	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	1,781	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	85	0	0	192.00
194.00	07950	TRANSPORTATION	0	0	2	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
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)	12,916	166,078	180,232	37,876	47,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	1,330,569					5.06
6.00	00600	MAINTENANCE & REPAIRS	3	24				6.00
7.00	00700	OPERATION OF PLANT	72,688	0	283,324			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,321	0	369	8,000		8.00
9.00	00900	HOUSEKEEPING	28,636	1	7,573	0	119,447	9.00
10.00	01000	DIETARY	38,802	3	9,711	6	2,083	10.00
11.00	01100	CAFETERIA	1,351	0	8,944	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	37,287	0	2,736	0	10	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,475	0	4,454	0	1,129	16.00
17.00	01700	SOCIAL SERVICE	14,172	0	1,136	0	19	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	186,435	8	64,912	4,431	43,705	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	115,088	3	42,234	902	12,330	50.00
53.00	05300	ANESTHESIOLOGY	2,241	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,249	1	30,122	721	9,235	54.00
60.00	06000	LABORATORY	96,571	1	11,588	0	3,250	60.00
65.00	06500	RESPIRATORY THERAPY	15,795	0	7,672	37	1,927	65.00
65.01	06501	SLEEP LAB	4,137	1	0	7	0	65.01
66.00	06600	PHYSICAL THERAPY	71,146	1	16,986	501	8,301	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,447	0	3,587	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,447	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	4,452	0	2,079	4	10	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	128,641	0	6,242	0	1,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,723	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,360	1	4,347	0	545	73.00
76.97	07697	CARDIAC REHABILITATION	14,150	1	5,560	0	1,265	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	45,657	0	12,705	190	4,642	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,518	0	0	0	0	90.00
91.00	09100	EMERGENCY	107,073	2	26,608	1,205	11,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	18,658	0	9,136	0	2,511	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,322,523	23	278,701	8,000	104,042	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,153	0	2,879	0	136	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,988	1	0	0	15,269	192.00
194.00	07950	TRANSPORTATION	1,851	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	2,054	0	1,744	0	0	194.01
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)	1,330,569	24	283,324	8,000	119,447	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	140,669					10.00
11.00	01100	CAFETERIA	58,044	133,999				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,588	92,728			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	79,257		16.00
17.00	01700	SOCIAL SERVICE	0	2,012	4,022	0	33,268	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	72,265	46,514	49,574	50,919	28,015	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,036	15,153	17,498	6,642	3,502	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,307	0	3,764	0	54.00
60.00	06000	LABORATORY	0	11,094	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,383	0	0	0	65.00
65.01	06501	SLEEP LAB	0	1,041	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	8,689	0	2,657	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,847	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	296	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	338	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,632	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	3,411	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,158	1,626	1,107	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,184	3,903	221	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,839	2,688	0	0	90.00
91.00	09100	EMERGENCY	7,324	11,101	10,972	13,283	1,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	1,323	2,445	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,669	132,910	92,728	78,593	33,268	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	664	0	192.00
194.00	07950	TRANSPORTATION	0	400	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	689	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	14,634	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	140,669	148,633	92,728	79,257	33,268	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	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	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,224,638	0	1,224,638	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		927,157	0	927,157	50.00
53.00	05300	ANESTHESIOLOGY		8,042	0	8,042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		545,721	0	545,721	54.00
60.00	06000	LABORATORY		283,099	0	283,099	60.00
65.00	06500	RESPIRATORY THERAPY		113,600	0	113,600	65.00
65.01	06501	SLEEP LAB		8,226	0	8,226	65.01
66.00	06600	PHYSICAL THERAPY		279,314	0	279,314	66.00
67.00	06700	OCCUPATIONAL THERAPY		56,500	0	56,500	67.00
68.00	06800	SPEECH PATHOLOGY		3,556	0	3,556	68.00
68.01	03040	AUDIOLOGY		27,478	0	27,478	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		200,474	0	200,474	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		23,493	0	23,493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		270,286	0	270,286	73.00
76.97	07697	CARDIAC REHABILITATION		84,119	0	84,119	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		190,825	0	190,825	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		14,505	0	14,505	90.00
91.00	09100	EMERGENCY		481,937	0	481,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER		132,290	0	132,290	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,875,260	0	4,875,260	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN		32,798	0	32,798	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		19,680	0	19,680	192.00
194.00	07950	TRANSPORTATION		10,957	0	10,957	194.00
194.01	07951	FUND DEVELOPMENT		20,280	0	20,280	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	14,634	0	14,634	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,973,609	0	4,973,609	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATION S (TELEPHONES)	DATA PROCESSING (WORK ORDERS)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,100					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		827,543				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	621	967	9,932,637			4.00
5.01	01160	COMMUNICATIONS	89	14,612	0	370		5.01
5.02	00550	DATA PROCESSING	1,584	165,337	0	24	2,852	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,869	2,334	122,060	7	198	5.03
5.04	00570	ADMITTING	913	778	100	13	112	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,360	1,001	0	6	26	5.05
5.06	00590	OTHER ADMIN & GENERAL	7,727	15,581	502,079	67	1,521	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,091	5,533	235,139	8	32	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,054	2,387	238,387	8	14	9.00
10.00	01000	DIETARY	2,634	2,672	245,191	7	2	10.00
11.00	01100	CAFETERIA	2,426	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	742	28,435	469,441	2	3	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,208	271	0	16	94	16.00
17.00	01700	SOCIAL SERVICE	308	0	185,449	1	22	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,606	47,903	2,051,659	61	159	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,455	319,868	932,141	38	76	50.00
53.00	05300	ANESTHESIOLOGY	0	2,367	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,170	82,706	772,548	18	73	54.00
60.00	06000	LABORATORY	3,143	17,337	664,262	17	65	60.00
65.00	06500	RESPIRATORY THERAPY	2,081	11,237	124,871	0	9	65.00
65.01	06501	SLEEP LAB	0	1,106	55,494	11	0	65.01
66.00	06600	PHYSICAL THERAPY	4,607	5,219	850,748	23	87	66.00
67.00	06700	OCCUPATIONAL THERAPY	973	600	208,631	0	7	67.00
68.00	06800	SPEECH PATHOLOGY	0	605	32,735	0	4	68.00
68.01	03040	AUDIOLOGY	564	1,839	45,103	0	9	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,693	2,673	108,621	0	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179	1,013	582,381	9	126	73.00
76.97	07697	CARDIAC REHABILITATION	1,508	8,224	134,965	5	46	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,446	2,157	181,720	0	52	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	127,264	0	0	90.00
91.00	09100	EMERGENCY	7,217	50,225	829,052	21	65	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	2,478	17,406	149,404	8	49	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,846	812,393	9,849,445	370	2,852	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	781	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,446	1,750	0	0	192.00
194.00	07950	TRANSPORTATION	0	12,704	16,987	0	0	194.00
194.01	07951	FUND DEVELOPMENT	473	0	64,455	0	0	194.01
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)	3,213,727	564,655	2,994,745	22,923	2,515,627	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.097085	0.682327	0.301506	61.954054	882.057153	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,213	12,916	166,078	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002136	34.908108	58.232118	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: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description			PURCHASING RECEIVING AND STORES (SUPPLY EXP ENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliatio n	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	336,484					5.03
5.04	00570	ADMITTING	282	21,615,047				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	120,986,023			5.05
5.06	00590	OTHER ADMIN & GENERAL	105,244	0	0	-5,122,143	26,179,579	5.06
6.00	00600	MAINTENANCE & REPAIRS	39	0	0	0	54	6.00
7.00	00700	OPERATION OF PLANT	66,687	0	0	0	1,430,168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	85,013	8.00
9.00	00900	HOUSEKEEPING	22,448	0	0	0	563,430	9.00
10.00	01000	DIETARY	335	0	0	0	763,438	10.00
11.00	01100	CAFETERIA	0	0	0	0	26,584	11.00
13.00	01300	NURSING ADMINISTRATION	3,546	0	0	0	733,633	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	540,578	16.00
17.00	01700	SOCIAL SERVICE	1	0	0	0	278,846	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,194	5,167,950	5,899,905	0	3,668,351	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,980	569,138	9,247,210	0	2,264,402	50.00
53.00	05300	ANESTHESIOLOGY	5,614	211,099	2,064,358	0	44,091	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,621	2,345,917	34,169,112	0	2,149,510	54.00
60.00	06000	LABORATORY	32,854	4,944,125	25,257,934	0	1,900,070	60.00
65.00	06500	RESPIRATORY THERAPY	1,124	2,361,553	4,459,181	0	310,781	65.00
65.01	06501	SLEEP LAB	317	5,659	750,628	0	81,406	65.01
66.00	06600	PHYSICAL THERAPY	6,905	1,051,536	4,489,910	0	1,399,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	468,676	848,132	0	323,598	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,204	86,943	0	48,140	68.00
68.01	03040	AUDIOLOGY	0	0	144,182	0	87,594	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,092	964,969	2,220,828	0	2,531,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,375	1,424,970	0	447,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,342	2,819,742	14,400,363	0	2,525,522	73.00
76.97	07697	CARDIAC REHABILITATION	822	0	379,672	0	278,411	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,677	61,443	3,509,426	0	898,312	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	93	480,489	0	167,589	90.00
91.00	09100	EMERGENCY	11,565	486,568	10,712,552	0	2,106,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	1,309	0	440,228	0	367,096	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,998	21,615,047	120,986,023	-5,122,143	26,021,289	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	3,325	0	0	0	42,353	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	158	0	0	0	39,108	192.00
194.00	07950	TRANSPORTATION	3	0	0	0	36,420	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	40,409	194.01
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)	468,027	360,827	491,537		5,122,143	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.390934	0.016693	0.004063		0.195654	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	180,232	37,876	47,418		1,330,569	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.535633	0.001752	0.000392		0.050825	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: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description		MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS	649				6.00
7.00	00700	OPERATION OF PLANT	0	76,846			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100	217,687		8.00
9.00	00900	HOUSEKEEPING	27	2,054	0	12,274	9.00
10.00	01000	DIETARY	88	2,634	170	214	10.00
11.00	01100	CAFETERIA	0	2,426	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7	742	0	1	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3	1,208	0	116	16.00
17.00	01700	SOCIAL SERVICE	0	308	0	2	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	202	17,606	120,569	4,491	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77	11,455	24,539	1,267	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26	8,170	19,607	949	54.00
60.00	06000	LABORATORY	30	3,143	0	334	60.00
65.00	06500	RESPIRATORY THERAPY	2	2,081	1,006	198	65.00
65.01	06501	SLEEP LAB	28	0	185	0	65.01
66.00	06600	PHYSICAL THERAPY	26	4,607	13,639	853	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	973	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	564	0	1	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10	1,693	0	116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17	1,179	0	56	73.00
76.97	07697	CARDIAC REHABILITATION	16	1,508	0	130	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	8	3,446	5,165	477	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	52	7,217	32,800	1,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	4	2,478	7	258	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	623	75,592	217,687	10,691	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2	781	0	14	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	24	0	0	1,569	192.00
194.00	07950	TRANSPORTATION	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	473	0	0	194.01
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)	65	1,709,986	103,871	719,376	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.100154	22.252115	0.477158	58.609744	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24	283,324	8,000	119,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.036980	3.686906	0.036750	9.731709	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: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description			CAFETERIA (MEALS FTES)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	19,446					11.00
13.00	01300	NURSING ADMINISTRATION	811	129,878				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	358			16.00
17.00	01700	SOCIAL SERVICE	292	5,633	0	6,079		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,750	69,435	230	5,119	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,199	24,508	30	640	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,786	0	17	0	0	54.00
60.00	06000	LABORATORY	1,610	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	491	0	0	0	0	65.00
65.01	06501	SLEEP LAB	151	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,261	0	12	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	268	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	43	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	49	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	382	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	495	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	168	2,278	5	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	317	5,466	1	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	412	3,765	0	0	0	90.00
91.00	09100	EMERGENCY	1,611	15,368	60	320	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	192	3,425	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,288	129,878	355	6,079	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	3	0	0	192.00
194.00	07950	TRANSPORTATION	58	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	100	0	0	0	0	194.01
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)	491,815	914,253	680,024	387,412	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.291320	7.039322	1,899.508380	63.729561	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	148,633	92,728	79,257	33,268	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.890826	0.713962	221.388268	5.472611	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: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/24/2021 8:15 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	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7,026,757		7,026,757	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,395,463		3,395,463	0	0 50.00
53.00	05300 ANESTHESIOLOGY	52,718		52,718	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,894,312		2,894,312	0	0 54.00
60.00	06000 LABORATORY	2,402,062		2,402,062	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	442,397	0	442,397	0	0 65.00
65.01	06501 SLEEP LAB	101,243	0	101,243	0	0 65.01
66.00	06600 PHYSICAL THERAPY	1,887,406	0	1,887,406	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	415,340	0	415,340	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	58,647	0	58,647	0	0 68.00
68.01	03040 AUDIOLOGY	118,580	0	118,580	0	0 68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	3,080,407		3,080,407	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	534,563		534,563	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,061,688		3,061,688	0	0 73.00
76.97	07697 CARDIAC REHABILITATION	403,843		403,843	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,229,568		1,229,568	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	237,301		237,301	0	0 90.00
91.00	09100 EMERGENCY	3,101,634		3,101,634	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	554,298		554,298	0	0 92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	538,151		538,151	0	0 93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	31,536,378	0	31,536,378	0	0 200.00
201.00	Less Observation Beds	554,298		554,298		0 201.00
202.00	Total (see instructions)	30,982,080	0	30,982,080	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/24/2021 8:15 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	5,120,993		5,120,993					30.00	
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	569,138	8,678,072	9,247,210	0.367188	0.000000			50.00	
53.00	05300	ANESTHESIOLOGY	211,099	1,853,259	2,064,358	0.025537	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,361,741	31,807,371	34,169,112	0.084706	0.000000			54.00	
60.00	06000	LABORATORY	4,944,125	20,313,809	25,257,934	0.095101	0.000000			60.00	
65.00	06500	RESPIRATORY THERAPY	2,345,729	2,113,452	4,459,181	0.099210	0.000000			65.00	
65.01	06501	SLEEP LAB	5,659	744,969	750,628	0.134878	0.000000			65.01	
66.00	06600	PHYSICAL THERAPY	1,051,536	3,438,374	4,489,910	0.420366	0.000000			66.00	
67.00	06700	OCCUPATIONAL THERAPY	468,676	379,456	848,132	0.489712	0.000000			67.00	
68.00	06800	SPEECH PATHOLOGY	36,204	50,739	86,943	0.674545	0.000000			68.00	
68.01	03040	AUDIOLOGY	0	144,182	144,182	0.822433	0.000000			68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	964,969	1,255,859	2,220,828	1.387053	0.000000			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,375	1,304,595	1,424,970	0.375140	0.000000			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,819,742	11,580,621	14,400,363	0.212612	0.000000			73.00	
76.97	07697	CARDIAC REHABILITATION	0	379,672	379,672	1.063663	0.000000			76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	61,443	3,447,983	3,509,426	0.350362	0.000000			76.98	
OUTPATIENT SERVICE COST CENTERS											
90.00	09000	CLINIC	93	480,396	480,489	0.493874	0.000000			90.00	
91.00	09100	EMERGENCY	486,568	10,225,984	10,712,552	0.289533	0.000000			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	46,957	731,955	778,912	0.711631	0.000000			92.00	
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	440,228	440,228	1.222437	0.000000			93.00	
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE								113.00	
200.00		Subtotal (see instructions)	21,615,047	99,370,976	120,986,023					200.00	
201.00		Less Observation Beds								201.00	
202.00		Total (see instructions)	21,615,047	99,370,976	120,986,023					202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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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
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
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
65.01	06501	SLEEP LAB	0.000000			65.01
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
68.01	03040	AUDIOLOGY	0.000000			68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
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	0.000000			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000			93.00
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: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/24/2021 8:15 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	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7,026,757		7,026,757	0	7,026,757 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,395,463		3,395,463	0	3,395,463 50.00
53.00	05300 ANESTHESIOLOGY	52,718		52,718	0	52,718 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,894,312		2,894,312	0	2,894,312 54.00
60.00	06000 LABORATORY	2,402,062		2,402,062	0	2,402,062 60.00
65.00	06500 RESPIRATORY THERAPY	442,397	0	442,397	0	442,397 65.00
65.01	06501 SLEEP LAB	101,243	0	101,243	0	101,243 65.01
66.00	06600 PHYSICAL THERAPY	1,887,406	0	1,887,406	0	1,887,406 66.00
67.00	06700 OCCUPATIONAL THERAPY	415,340	0	415,340	0	415,340 67.00
68.00	06800 SPEECH PATHOLOGY	58,647	0	58,647	0	58,647 68.00
68.01	03040 AUDIOLOGY	118,580	0	118,580	0	118,580 68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	3,080,407		3,080,407	0	3,080,407 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	534,563		534,563	0	534,563 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,061,688		3,061,688	0	3,061,688 73.00
76.97	07697 CARDIAC REHABILITATION	403,843		403,843	0	403,843 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,229,568		1,229,568	0	1,229,568 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	237,301		237,301	0	237,301 90.00
91.00	09100 EMERGENCY	3,101,634		3,101,634	0	3,101,634 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	554,298		554,298		554,298 92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	538,151		538,151	0	538,151 93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	31,536,378	0	31,536,378	0	31,536,378 200.00
201.00	Less Observation Beds	554,298		554,298		554,298 201.00
202.00	Total (see instructions)	30,982,080	0	30,982,080	0	30,982,080 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/24/2021 8:15 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	5,120,993		5,120,993		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	569,138	8,678,072	9,247,210	0.367188	0.000000
53.00	05300	ANESTHESIOLOGY	211,099	1,853,259	2,064,358	0.025537	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,361,741	31,807,371	34,169,112	0.084706	0.000000
60.00	06000	LABORATORY	4,944,125	20,313,809	25,257,934	0.095101	0.000000
65.00	06500	RESPIRATORY THERAPY	2,345,729	2,113,452	4,459,181	0.099210	0.000000
65.01	06501	SLEEP LAB	5,659	744,969	750,628	0.134878	0.000000
66.00	06600	PHYSICAL THERAPY	1,051,536	3,438,374	4,489,910	0.420366	0.000000
67.00	06700	OCCUPATIONAL THERAPY	468,676	379,456	848,132	0.489712	0.000000
68.00	06800	SPEECH PATHOLOGY	36,204	50,739	86,943	0.674545	0.000000
68.01	03040	AUDIOLOGY	0	144,182	144,182	0.822433	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	964,969	1,255,859	2,220,828	1.387053	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,375	1,304,595	1,424,970	0.375140	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,819,742	11,580,621	14,400,363	0.212612	0.000000
76.97	07697	CARDIAC REHABILITATION	0	379,672	379,672	1.063663	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	61,443	3,447,983	3,509,426	0.350362	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	93	480,396	480,489	0.493874	0.000000
91.00	09100	EMERGENCY	486,568	10,225,984	10,712,552	0.289533	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	46,957	731,955	778,912	0.711631	0.000000
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	440,228	440,228	1.222437	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	21,615,047	99,370,976	120,986,023		
201.00		Less Observation Beds					
202.00		Total (see instructions)	21,615,047	99,370,976	120,986,023		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/24/2021 8:15 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
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
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
65.01	06501	SLEEP LAB	0.000000			65.01
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
68.01	03040	AUDIOLOGY	0.000000			68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
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	0.000000			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000			93.00
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: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Capital Related Cost (from Wkst. C, 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	927,157	9,247,210	0.100263	116,203	11,651	50.00
53.00	05300	ANESTHESIOLOGY	8,042	2,064,358	0.003896	44,590	174	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	545,721	34,169,112	0.015971	709,225	11,327	54.00
60.00	06000	LABORATORY	283,099	25,257,934	0.011208	1,403,365	15,729	60.00
65.00	06500	RESPIRATORY THERAPY	113,600	4,459,181	0.025476	536,638	13,671	65.00
65.01	06501	SLEEP LAB	8,226	750,628	0.010959	0	0	65.01
66.00	06600	PHYSICAL THERAPY	279,314	4,489,910	0.062209	132,335	8,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,500	848,132	0.066617	33,901	2,258	67.00
68.00	06800	SPEECH PATHOLOGY	3,556	86,943	0.040900	8,846	362	68.00
68.01	03040	AUDIOLOGY	27,478	144,182	0.190579	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	200,474	2,220,828	0.090270	236,804	21,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,493	1,424,970	0.016487	101,775	1,678	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	270,286	14,400,363	0.018769	618,496	11,609	73.00
76.97	07697	CARDIAC REHABILITATION	84,119	379,672	0.221557	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	190,825	3,509,426	0.054375	269	15	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14,505	480,489	0.030188	0	0	90.00
91.00	09100	EMERGENCY	481,937	10,712,552	0.044988	11,920	536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	96,604	778,912	0.124024	3,060	380	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	132,290	440,228	0.300503	0	0	93.00
200.00		Total (lines 50 through 199)	3,747,226	115,865,030		3,957,427	98,998	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/24/2021 8:15 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
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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	0	0	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	0	0	93.00
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: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/24/2021 8:15 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	9,247,210	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,064,358	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,169,112	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,257,934	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,459,181	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	750,628	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,489,910	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	848,132	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	86,943	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	144,182	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	2,220,828	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,424,970	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,400,363	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	379,672	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	3,509,426	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	480,489	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,712,552	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	778,912	0.000000	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	440,228	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	115,865,030		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 8:15 am	
Cost Center Description				Title XVIII		Hospital		Cost	
				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	116,203	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	44,590	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	709,225	0	0	0	54.00
60.00	06000	LABORATORY		0.000000	1,403,365	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	536,638	0	0	0	65.00
65.01	06501	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	132,335	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	33,901	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	8,846	0	0	0	68.00
68.01	03040	AUDIOLOGY		0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0.000000	236,804	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	101,775	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	618,496	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	269	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	11,920	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0.000000	3,060	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER		0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)			3,957,427	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/24/2021 8:15 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	0.367188	0	2,540,838	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.025537	0	468,669	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084706	0	9,998,903	0	0	54.00	
60.00	06000	LABORATORY	0.095101	0	5,327,968	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.099210	0	737,263	0	0	65.00	
65.01	06501	SLEEP LAB	0.134878	0	240,974	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.420366	0	1,231,959	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.489712	0	142,323	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.674545	0	8,071	0	0	68.00	
68.01	03040	AUDIOLOGY	0.822433	0	43,474	0	0	68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.387053	0	317,801	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375140	0	471,825	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.212612	0	5,370,344	6,890	0	73.00	
76.97	07697	CARDIAC REHABILITATION	1.063663	0	188,253	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.350362	0	1,229,986	0	0	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.493874	0	46,149	0	0	90.00	
91.00	09100	EMERGENCY	0.289533	0	3,003,993	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.711631	0	343,728	0	0	92.00	
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.222437	0	355,040	0	0	93.00	
200.00		Subtotal (see instructions)		0	32,067,561	6,890	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	32,067,561	6,890	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/24/2021 8:15 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	932,965	0					50.00
53.00	05300	ANESTHESIOLOGY	11,968	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	846,967	0					54.00
60.00	06000	LABORATORY	506,695	0					60.00
65.00	06500	RESPIRATORY THERAPY	73,144	0					65.00
65.01	06501	SLEEP LAB	32,502	0					65.01
66.00	06600	PHYSICAL THERAPY	517,874	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	69,697	0					67.00
68.00	06800	SPEECH PATHOLOGY	5,444	0					68.00
68.01	03040	AUDIOLOGY	35,754	0					68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	440,807	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,000	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,141,800	1,465					73.00
76.97	07697	CARDIAC REHABILITATION	200,238	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	430,940	0					76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	22,792	0					90.00
91.00	09100	EMERGENCY	869,755	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	244,608	0					92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	434,014	0					93.00
200.00		Subtotal (see instructions)	6,994,964	1,465					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	6,994,964	1,465					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/24/2021 8:15 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)		7,104	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,937	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)		2,393	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,958	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)		1,957	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		126	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)		126	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,135	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)		1,398	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)		1,162	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)		7,026,757	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)		22,502	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)		22,502	25.00
26.00	Total swing-bed cost (see instructions)		4,034,154	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,992,603	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,992,603	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)		1,018.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,156,497	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,156,497	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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)					872,645	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,029,142	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)					1,424,478	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,184,008	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,608,486	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)					544	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,018.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					554,298	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1336		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/24/2021 8:15 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	1,224,638	7,026,757	0.174282	554,298	96,604	90.00		
91.00	Nursing School cost	0	7,026,757	0.000000	554,298	0	91.00		
92.00	Allied health cost	0	7,026,757	0.000000	554,298	0	92.00		
93.00	All other Medical Education	0	7,026,757	0.000000	554,298	0	93.00		

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/24/2021 8:15 am	
Cost Center Description		Title XVIII	Hospital	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		1,477,246		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.367188	116,203	42,668	50.00
53.00	05300 ANESTHESIOLOGY	0.025537	44,590	1,139	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084706	709,225	60,076	54.00
60.00	06000 LABORATORY	0.095101	1,403,365	133,461	60.00
65.00	06500 RESPIRATORY THERAPY	0.099210	536,638	53,240	65.00
65.01	06501 SLEEP LAB	0.134878	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.420366	132,335	55,629	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.489712	33,901	16,602	67.00
68.00	06800 SPEECH PATHOLOGY	0.674545	8,846	5,967	68.00
68.01	03040 AUDIOLOGY	0.822433	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.387053	236,804	328,460	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.375140	101,775	38,180	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.212612	618,496	131,500	73.00
76.97	07697 CARDIAC REHABILITATION	1.063663	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.350362	269	94	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.493874	0	0	90.00
91.00	09100 EMERGENCY	0.289533	11,920	3,451	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.711631	3,060	2,178	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	1.222437	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,957,427	872,645	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)		3,957,427		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1336 Component CCN: 14-Z336	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/24/2021 8:15 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				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.367188	36,357	13,350	50.00
53.00	05300 ANESTHESIOLOGY	0.025537	2,710	69	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084706	193,336	16,377	54.00
60.00	06000 LABORATORY	0.095101	1,032,171	98,160	60.00
65.00	06500 RESPIRATORY THERAPY	0.099210	761,537	75,552	65.00
65.01	06501 SLEEP LAB	0.134878	5,659	763	65.01
66.00	06600 PHYSICAL THERAPY	0.420366	507,204	213,211	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.489712	264,620	129,588	67.00
68.00	06800 SPEECH PATHOLOGY	0.674545	13,492	9,101	68.00
68.01	03040 AUDIOLOGY	0.822433	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.387053	195,228	270,792	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.375140	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.212612	749,366	159,324	73.00
76.97	07697 CARDIAC REHABILITATION	1.063663	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.350362	14,254	4,994	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.493874	0	0	90.00
91.00	09100 EMERGENCY	0.289533	6,132	1,775	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.711631	60	43	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	1.222437	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,782,126	993,099	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)		3,782,126		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/24/2021 8:15 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,996,429 1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)			0 2.00
3.00	OPPI payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,996,429 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			7,066,393 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			60,466 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,302,162 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,703,765 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,703,765 30.00
31.00	Primary payer payments			336 31.00
32.00	Subtotal (line 30 minus line 31)			1,703,429 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			872,054 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			566,835 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			687,307 36.00
37.00	Subtotal (see instructions)			2,270,264 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,270,264 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,448,613 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			-1,178,349 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/24/2021 8:15 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		2,498,572		3,267,598	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	01/26/2021	181,015	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	01/26/2021	39,071		0	3.50
3.51		06/17/2021	38,932		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)		-78,003		181,015	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,420,569		3,448,613	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		586,777		1,178,349	6.02
7.00	Total Medicare program liability (see instructions)		1,833,792		2,270,264	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: 14-1336

Period:

Worksheet E-1

Component CCN: 14-Z336

From 07/01/2020

Part I

To 06/30/2021

Date/Time Prepared:

11/24/2021 8:15 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		4,609,954		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	01/26/2021	172,202		0	3.50
3.51		06/17/2021	97,692		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)		-269,894		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)		4,340,060		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		762,783		0	6.02
7.00	Total Medicare program liability (see instructions)		3,577,277		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: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/24/2021 8:15 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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2 Date/Time Prepared: 11/24/2021 8:15 am	
		Component CCN:14-Z336			
		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)		2,634,571	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)		1,003,030	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		2,560	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)		3,637,601	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,637,601	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)		3,637,601	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		60,324	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		3,577,277	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)		3,577,277	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		4,340,060	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)		-762,783	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1336	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/24/2021 8:15 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,029,142	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,029,142	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,049,433	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,049,433	19.00
20.00	Deductibles (exclude professional component)		326,988	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,722,445	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,722,445	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		171,303	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		111,347	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		135,589	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,833,792	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)		1,833,792	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,420,569	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)		-586,777	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: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/24/2021 8:15 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	-55,649	0	0	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	13,050,154	0	0	0	4.00
5.00	Other receivable	765,969	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,088,278	0	0	0	6.00
7.00	Inventory	768,610	0	0	0	7.00
8.00	Prepaid expenses	231,277	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,672,083	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,052,874	0	0	0	12.00
13.00	Land improvements	1,469,318	0	0	0	13.00
14.00	Accumulated depreciation	-1,266,964	0	0	0	14.00
15.00	Buildings	29,066,374	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	21,000	0	0	0	17.00
18.00	Accumulated depreciation	-6,825	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	11,119,947	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	42,455,724	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	20,996,608	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,996,608	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,124,415	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,318,897	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,407,497	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,291,342	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	12,158,771	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,176,507	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	27,368,774	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	17,701,892	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	45,070,666	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	69,247,173	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,877,242	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,877,242	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,124,415	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/24/2021 8:15 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		-12,046,051		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,923,293				2.00
3.00	Total (sum of line 1 and line 2)		1,877,242		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,877,242		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,877,242		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2021 8:15 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,439,178		2,439,178	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,521,772		2,521,772	5.00
6.00	Swing bed - NF	176,612		176,612	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)	5,137,562		5,137,562	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)	5,137,562		5,137,562	17.00
18.00	Ancillary services	16,032,581	89,630,130	105,662,711	18.00
19.00	Outpatient services	555,439	12,035,855	12,591,294	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	PRO FEES	15,824	124,306	140,130	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,741,406	101,790,291	123,531,697	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,806,041		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)		38,806,041		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/24/2021 8:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,531,697	1.00
2.00	Less contractual allowances and discounts on patients' accounts	76,629,509	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,902,188	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,806,041	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,096,147	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	917	13.00
14.00	Revenue from meals sold to employees and guests	111,430	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	693	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	5,352	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	40,077	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,510,689	24.00
24.01	GRANTS	157,431	24.01
24.50	COVID-19 PHE Funding	-238,265	24.50
25.00	Total other income (sum of lines 6-24)	1,588,324	25.00
26.00	Total (line 5 plus line 25)	9,684,471	26.00
27.00	NON-OPERATING EXPENSES	-4,238,822	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-4,238,822	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,923,293	29.00