

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet S Parts I-III Date/Time Prepared: 1/25/2022 1:43 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 04/01/2021 7. Contractor No. 06101 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VALLEY WEST COMMUNITY HOSPITAL (14-1340) for the cost reporting period beginning 09/01/2020 and ending 08/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	58,051	-310,696	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing Bed - SNF	0	-213,261	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	-155,210	-310,696	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: 14-1340		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 1:43 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1302 N. MAIN STREET			PO Box:				1.00			
2.00	City: SANDWICH			State: IL		Zip Code: 60548-		County:			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		VALLEY WEST COMMUNITY HOSPITAL	141340	20994	1	08/02/2004	N	0	0	
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF		VALLEY WEST COMMUNITY HOSPITAL SWB	14Z340	20994		10/18/2018	N	0	0	
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										
17.10	Hospital-Based (CORF) I										
17.20	Hospital-Based (OPT) I										
17.30	Hospital-Based (OOT) I										
17.40	Hospital-Based (OSP) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2020		08/31/2021		20.00
21.00	Type of Control (see instructions)						2				21.00
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1340

Period:
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	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.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
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		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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			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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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. 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
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1340

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

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			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)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 1:43 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	31,631	0	618,684 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0640	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1340		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 1:43 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 131				141.00	
142.00	Street: 251 E HURON STREET		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60611				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.					Y			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N			146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
161.10	CORF				N	N	N		161.10	
161.20	OPT				N	N	N		161.20	
161.30	OOT				N	N	N		161.30	
161.40	OSP				N	N	N		161.40	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								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)							N	168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	
							Beginning	Ending		
							1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 1:43 pm
		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: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part II Date/Time Prepared: 1/25/2022 1:43 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	
		1.00	2.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	
		1.00	2.00	
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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		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	12/09/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1340		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part II Date/Time Prepared: 1/25/2022 1:43 pm	
		Description		Y/N	Y/N		
		0		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00	
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00	
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00	
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00	
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00	
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00	
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00	
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00	
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00	
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.				N	35.00	
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?				Y	36.00	
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00	
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00	
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00	
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00	
				1.00	2.00		
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	XXXXXXXXXX		XXXXXXXXXX		41.00	
42.00	Enter the employer/company name of the cost report preparer.	XXXXXXXXXX				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	XXXXXXXXXX		XXXXXXXXXX		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/25/2022 1:43 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	XXXXXXXXXX	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: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	70,292.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	70,292.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	228.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	70,520.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OPT	99.20				0	25.20
25.30 CMHC - OOT	99.30				0	25.30
25.40 CMHC - OSP	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		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: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	832	31	1,914			1.00
2.00	HMO and other (see instructions)	200	190				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	536	0	563			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		117	117			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,368	148	2,594			7.00
8.00	INTENSIVE CARE UNIT	4	0	7			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		16	316			13.00
14.00	Total (see instructions)	1,372	164	2,917	0.00	169.07	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			6			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OPT	0	0	0	0.00	0.00	25.20
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
25.40	CMHC - OSP	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	169.07	27.00
28.00	Observation Bed Days		0	680			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	10	74			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

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	248	12	728	1.00
2.00 HMO and other (see instructions)			55	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	248	12	728	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OPT	0.00					25.20
25.30 CMHC - OOT	0.00					25.30
25.40 CMHC - OSP	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet S-10 Date/Time Prepared: 1/25/2022 1:43 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.247673 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,676,146		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	27,097,860		6.00
7.00	Medicaid cost (line 1 times line 6)	6,711,408		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)	35,262		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)	35,262		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)	733,827	331,579	1,065,406 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	181,749	331,579	513,328 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)	181,749	331,579	513,328 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,295,681		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	370,016		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	569,255		27.01
28.00	Non-Medicare bad debt expense (see instructions)	726,426		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	379,155		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	892,483		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	927,745		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,797,451	1,797,451	-480,221	1,317,230	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	451,601	451,601	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,456	160,584	181,040	2,485,965	2,667,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,517,233	16,705,510	18,222,743	-1,413,396	16,809,347	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	276,747	2,099,644	2,376,391	-50,340	2,326,051	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,780	99,780	0	99,780	8.00
9.00	00900	HOUSEKEEPING	303,300	376,577	679,877	-130,492	549,385	9.00
10.00	01000	DIETARY	438,732	384,558	823,290	-496,947	326,343	10.00
11.00	01100	CAFETERIA	0	0	0	354,543	354,543	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	274,465	93,347	367,812	-4,503	363,309	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,855	41,540	90,395	-12,285	78,110	14.00
15.00	01500	PHARMACY	479,003	1,977,966	2,456,969	-1,913,159	543,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	135,484	18,088	153,572	18,192	171,764	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,108,159	1,205,521	4,313,680	-1,201,646	3,112,034	30.00
31.00	03100	INTENSIVE CARE UNIT	11,261	2,984	14,245	-3,399	10,846	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	344,136	344,136	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,286,149	1,928,409	3,214,558	-392,704	2,821,854	50.00
51.00	05100	RECOVERY ROOM	123,797	30,098	153,895	-16,376	137,519	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	532,608	532,608	52.00
53.00	05300	ANESTHESIOLOGY	0	565,899	565,899	-19,259	546,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,364,850	1,054,791	2,419,641	-282,325	2,137,316	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	83,220	36,471	119,691	110,884	230,575	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	872,183	1,793,015	2,665,198	-565,442	2,099,756	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	183,661	183,661	64.00
65.00	06500	RESPIRATORY THERAPY	517,525	180,123	697,648	-87,246	610,402	65.00
66.00	06600	PHYSICAL THERAPY	413,288	155,797	569,085	-84,233	484,852	66.00
66.01	06601	O/P PHYSICAL THERAPY	419,414	120,574	539,988	25,835	565,823	66.01
69.00	06900	ELECTROCARDIOLOGY	38,450	16,680	55,130	-6,541	48,589	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,201,195	1,201,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	290,092	290,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	160,452	160,452	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	1,764,889	1,764,889	73.01
74.00	07400	RENAL DIALYSIS	0	15,823	15,823	0	15,823	74.00
76.00	03020	CLINICAL NUTRITION	0	6	6	445	451	76.00
76.01	03950	SLEEP LAB	0	31,001	31,001	0	31,001	76.01
76.97	07697	CARDIAC REHABILITATION	146,264	46,240	192,504	-25,943	166,561	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	32,623	21,715	54,338	16,390	70,728	90.00
91.00	09100	EMERGENCY	1,664,141	678,134	2,342,275	-513,939	1,828,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,575,599	31,638,326	45,213,925	240,492	45,454,417	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	6,484	6,484	-200	6,284	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	824,593	824,593	-240,741	583,852	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	449	449	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	13,575,599	32,469,403	46,045,002	0	46,045,002	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	209,781	1,527,011	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-28,646	422,955	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-29,909	2,637,096	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,876,282	7,933,065	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,326,051	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,780	8.00
9.00	00900	HOUSEKEEPING	0	549,385	9.00
10.00	01000	DIETARY	0	326,343	10.00
11.00	01100	CAFETERIA	-91,471	263,072	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	103,061	466,370	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,110	14.00
15.00	01500	PHARMACY	-600	543,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,137	3,137	16.00
17.00	01700	SOCIAL SERVICE	-6,752	165,012	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-12,310	3,099,724	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,846	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	344,136	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,821,854	50.00
51.00	05100	RECOVERY ROOM	0	137,519	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	532,608	52.00
53.00	05300	ANESTHESIOLOGY	-524,112	22,528	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-130,297	2,007,019	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	230,575	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-5,955	2,093,801	60.00
64.00	06400	INTRAVENOUS THERAPY	0	183,661	64.00
65.00	06500	RESPIRATORY THERAPY	-40,008	570,394	65.00
66.00	06600	PHYSICAL THERAPY	0	484,852	66.00
66.01	06601	O/P PHYSICAL THERAPY	-31,794	534,029	66.01
69.00	06900	ELECTROCARDIOLOGY	-6,871	41,718	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,201,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	290,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	160,452	73.00
73.01	07301	INJECTABLE DRUGS	0	1,764,889	73.01
74.00	07400	RENAL DIALYSIS	0	15,823	74.00
76.00	03020	CLINICAL NUTRITION	0	451	76.00
76.01	03950	SLEEP LAB	0	31,001	76.01
76.97	07697	CARDIAC REHABILITATION	-4,591	161,970	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	70,728	90.00
91.00	09100	EMERGENCY	-2,463	1,825,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OPT	0	0	99.20
99.30	09930	OOT	0	0	99.30
99.40	09940	OSP	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,476,082	35,978,335	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	-8,000	-1,716	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	-25,455	558,397	192.00
194.00	07950	COMMUNITY WELLNESS	0	449	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,509,537	36,535,465	200.00

RECLASSIFICATIONS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-6

Date/Time Prepared:
1/25/2022 1:43 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	160,452		1.00
2.00	INJECTABLE DRUGS	73.01	0	1,764,889		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
	TOTALS		0	1,925,341		
	B - NURSERY / DELIVERY & LABOR COSTS					
1.00	NURSERY	43.00	300,573	33,528		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	229,935	25,648		2.00
	TOTALS		530,508	59,176		
	C - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,201,195		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
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
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	1,201,195		
	D - IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	168,293	15,368		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		168,293	15,368		
	E - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	205,058	145,036		1.00
	TOTALS		205,058	145,036		
	F - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	111,580		1.00
	TOTALS		0	111,580		
	G - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	457,027		1.00
	TOTALS		0	457,027		
	H - CONTINUITY OF CARE					
1.00	SOCIAL SERVICE	17.00	76,075	17,125		1.00
	TOTALS		76,075	17,125		
	I - ROUTINE DIABETES					
1.00	ADULTS & PEDIATRICS	30.00	5,457	0		1.00
	TOTALS		5,457	0		
	J - ICU OBSERVATION					
1.00	ADULTS & PEDIATRICS	30.00	5,058	518		1.00
	TOTALS		5,058	518		
	K - MOB RECLASS					
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	137,902		1.00
2.00	O/P PHYSICAL THERAPY	66.01	0	97,123		2.00
3.00	CLINIC	90.00	0	24,891		3.00
	TOTALS		0	259,916		
	L - SOCIAL SERVICE					
1.00	EMERGENCY	91.00	70,472	5,710		1.00
	TOTALS		70,472	5,710		

RECLASSIFICATIONS

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Period:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	290,092		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
	TOTALS		0	290,092		
	N - MEDICAL DIRECTOR RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	2,325	0		1.00
2.00	OPERATING ROOM	50.00	90,000	350,650		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	53,050	219,600		3.00
4.00	RESPIRATORY THERAPY	65.00	2,325	0		4.00
	TOTALS		147,700	570,250		
	O - VW MOB BUILDING DEPRECIATION					
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,879		1.00
2.00	O/P PHYSICAL THERAPY	66.01	0	2,732		2.00
3.00	CLINIC	90.00	0	700		3.00
4.00	PHYSICIANS PRIVATE OFFICES	192.00	0	15,883		4.00
	TOTALS		0	23,194		
	P - VW MOB EQUIPMENT DEPRECIATION					
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	907		1.00
2.00	O/P PHYSICAL THERAPY	66.01	0	639		2.00
3.00	CLINIC	90.00	0	164		3.00
4.00	PHYSICIANS PRIVATE OFFICES	192.00	0	3,716		4.00
	TOTALS		0	5,426		
	Q - OB COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	1,271		1.00
	TOTALS		0	1,271		
	S - DIRECTLY ASSIGNED BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,374,385		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
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
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	TOTALS		0	2,374,385		
	U - RECLASS ORGANIZATIONAL INCENTIVE					
1.00	ADMINISTRATIVE & GENERAL	5.00	12,445	0		1.00
2.00	OPERATION OF PLANT	7.00	6,325	0		2.00
3.00	HOUSEKEEPING	9.00	4,720	0		3.00
4.00	DIETARY	10.00	3,050	0		4.00
5.00	CAFETERIA	11.00	9,906	0		5.00
6.00	NURSING ADMINISTRATION	13.00	34,686	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	595	0		7.00
8.00	PHARMACY	15.00	15,568	0		8.00
9.00	SOCIAL SERVICE	17.00	1,533	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	45,058	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	2,432	0		11.00
12.00	NURSERY	43.00	10,035	0		12.00
13.00	OPERATING ROOM	50.00	26,589	0		13.00
14.00	RECOVERY ROOM	51.00	1,436	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	4,375	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	31,873	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	3,457	0		17.00
18.00	LABORATORY	60.00	17,702	0		18.00
19.00	RESPIRATORY THERAPY	65.00	9,247	0		19.00
20.00	PHYSICAL THERAPY	66.00	2,663	0		20.00
21.00	O/P PHYSICAL THERAPY	66.01	6,658	0		21.00

RECLASSIFICATIONS

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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
22.00	CLINICAL NUTRITION	76.00	445	0	22.00
23.00	CARDIAC REHABILITATION	76.97	3,455	0	23.00
24.00	CLINIC	90.00	840	0	24.00
25.00	EMERGENCY	91.00	32,415	0	25.00
26.00	COMMUNITY WELLNESS	194.00	449	0	26.00
	TOTALS		287,957	0	
500.00	Grand Total: Increases		1,496,578	7,462,610	500.00

RECLASSIFICATIONS

Provider CCN: 14-1340

Period:
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		Decreases					1/25/2022 1:43 PM	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	1,855,615	0		1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	313	0		2.00	
3.00	ANESTHESIOLOGY	53.00	0	3,689	0		3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	60,327	0		4.00	
5.00	RESPIRATORY THERAPY	65.00	0	39	0		5.00	
6.00	PHYSICAL THERAPY	66.00	0	33	0		6.00	
7.00	O/P PHYSICAL THERAPY	66.01	0	35	0		7.00	
8.00	CLINIC	90.00	0	2,580	0		8.00	
9.00	OPERATING ROOM	50.00	0	2,710	0		9.00	
	TOTALS		0	1,925,341				
	B - NURSERY / DELIVERY & LABOR COSTS							
1.00	ADULTS & PEDIATRICS	30.00	530,508	59,176	0		1.00	
2.00		0.00	0	0	0		2.00	
	TOTALS		530,508	59,176				
	C - MEDICAL SUPPLIES CHARGED TO PATIENTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	331	0		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	70,070	0		2.00	
3.00	OPERATION OF PLANT	7.00	0	328	0		3.00	
4.00	HOUSEKEEPING	9.00	0	6,416	0		4.00	
5.00	DIETARY	10.00	0	983	0		5.00	
6.00	PHARMACY	15.00	0	9,335	0		6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	131,390	0		7.00	
8.00	OPERATING ROOM	50.00	0	334,507	0		8.00	
9.00	RECOVERY ROOM	51.00	0	4,024	0		9.00	
10.00	ANESTHESIOLOGY	53.00	0	15,570	0		10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,564	0		11.00	
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	12,979	0		12.00	
13.00	LABORATORY	60.00	0	408,891	0		13.00	
14.00	RESPIRATORY THERAPY	65.00	0	10,663	0		14.00	
15.00	PHYSICAL THERAPY	66.00	0	3,115	0		15.00	
16.00	O/P PHYSICAL THERAPY	66.01	0	9,810	0		16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	296	0		17.00	
18.00	CARDIAC REHABILITATION	76.97	0	562	0		18.00	
19.00	CLINIC	90.00	0	345	0		19.00	
20.00	EMERGENCY	91.00	0	150,392	0		20.00	
21.00	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00	0	200	0		21.00	
22.00	PHYSICIANS PRIVATE OFFICES	192.00	0	424	0		22.00	
	TOTALS		0	1,201,195				
	D - IV THERAPY							
1.00		0.00	0	0	0		1.00	
3.00	OPERATING ROOM	50.00	17,231	1,491	0		3.00	
4.00	RADIOLOGY-THERAPEUTIC	55.00	7,431	573	0		4.00	
5.00	EMERGENCY	91.00	143,631	13,304	0		5.00	
	TOTALS		168,293	15,368				
	E - CAFETERIA RECLASS							
1.00	DIETARY	10.00	205,058	145,036	0		1.00	
	TOTALS		205,058	145,036				
	F - WORKERS COMPENSATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	111,580	0		1.00	
	TOTALS		0	111,580				
	G - EQUIPMENT DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	457,027	9		1.00	
	TOTALS		0	457,027				
	H - CONTINUITY OF CARE							
1.00	ADMINISTRATIVE & GENERAL	5.00	76,075	17,125	0		1.00	
	TOTALS		76,075	17,125				
	I - ROUTINE DIABETES							
1.00	CAFETERIA	11.00	5,457	0	0		1.00	
	TOTALS		5,457	0				
	J - ICU OBSERVATION							
1.00	INTENSIVE CARE UNIT	31.00	5,058	518	0		1.00	
	TOTALS		5,058	518				
	K - MOB RECLASS							
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	259,916	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
	TOTALS		0	259,916				
	L - SOCIAL SERVICE							
1.00	SOCIAL SERVICE	17.00	70,472	5,710	0		1.00	
	TOTALS		70,472	5,710				

RECLASSIFICATIONS

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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	289,263	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	443	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	59	0		3.00
4.00	EMERGENCY	91.00	0	327	0		4.00
	TOTALS		0	290,092			
	N - MEDICAL DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	147,700	568,750	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	750	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	750	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		147,700	570,250			
	O - VW MOB BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,194	9		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
	TOTALS		0	23,194			
	P - VW MOB EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,426	9		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
	TOTALS		0	5,426			
	Q - OB COSTS						
1.00	EMERGENCY	91.00	0	1,271	0		1.00
	TOTALS		0	1,271			
	S - DIRECTLY ASSIGNED BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	146,584	0		1.00
2.00	OPERATION OF PLANT	7.00	0	56,337	0		2.00
3.00	HOUSEKEEPING	9.00	0	128,796	0		3.00
4.00	DIETARY	10.00	0	148,920	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	39,189	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,549	0		6.00
7.00	PHARMACY	15.00	0	63,777	0		7.00
8.00	SOCIAL SERVICE	17.00	0	359	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	537,621	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,830	0		10.00
11.00	OPERATING ROOM	50.00	0	214,741	0		11.00
12.00	RECOVERY ROOM	51.00	0	13,788	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	222,864	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	14,278	0		14.00
15.00	LABORATORY	60.00	0	174,253	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	87,307	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	83,748	0		17.00
18.00	O/P PHYSICAL THERAPY	66.01	0	71,472	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	6,245	0		19.00
21.00	CARDIAC REHABILITATION	76.97	0	28,836	0		21.00
22.00	CLINIC	90.00	0	7,280	0		22.00
23.00	EMERGENCY	91.00	0	313,611	0		23.00
	TOTALS		0	2,374,385			
	U - RECLASS ORGANIZATIONAL INCENTIVE						
1.00	ADMINISTRATIVE & GENERAL	5.00	287,957	0	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
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00

RECLASSIFICATIONS

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	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
	TOTALS		287,957	0		
500.00	Grand Total: Decreases		1,496,578	7,462,610		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1340

Period:
From 09/01/2020
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Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,794,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,423,326	327,357	0	327,357	244,600	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,160,277	1,481,199	0	1,481,199	186,466	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,377,603	1,808,556	0	1,808,556	431,066	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,377,603	1,808,556	0	1,808,556	431,066	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,794,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	21,506,083	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	7,455,010	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	30,755,093	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	30,755,093	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1340

Period:
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Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,797,451	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)	1,797,451	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,797,451				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,797,451				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1340

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Part III
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,632,851	0	20,632,851	0.770100	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,160,277	687	6,159,590	0.229900	0	2.00
3.00	Total (sum of lines 1-2)	26,793,128	687	26,792,441	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,527,011	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	422,955	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,949,966	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,527,011	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	422,955	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,949,966	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/25/2022 1:43 pm

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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A		0OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,431,957			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B		0RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,875,187			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-91,471	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-18,905	ADMINISTRATIVE & GENERAL	5.00	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-4,132	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER MISC INCOME	B	-164	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			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		
34.00	CORP BILLING MISC INCOME	B	-600	PHARMACY	15.00	0 34.00
35.00	MOI MRI SPACE RENTAL	B	-39,745	RADIOLOGY-DIAGNOSTIC	54.00	0 35.00
36.00	CORP BILLING MISC INCOME	B	298	RADIOLOGY-DIAGNOSTIC	54.00	0 36.00
37.00	CORP BILLING MISC INCOME	B	-9,900	RADIOLOGY-DIAGNOSTIC	54.00	0 37.00
38.00	RESEARCH REVENUE	B	-4,302	RADIOLOGY-DIAGNOSTIC	54.00	0 38.00
39.00	CORPORATE REVENUE MISC INCOME	B	-5,428	LABORATORY	60.00	0 39.00
39.01	MISC PT REVENUE	B	-1,820	O/P PHYSICAL THERAPY	66.01	0 39.01
39.02	OTHER MISC INCOME	B	-4,591	CARDIAC REHABILITATION	76.97	0 39.02
39.03	CORPORATE REVENUE MISC INCOME	B	-1,272	EMERGENCY	91.00	0 39.03
40.00	CORPORATE BILLING MISC INCOME	B	-95	EMERGENCY	91.00	0 40.00
41.00	CORPORATE BILLING MISC INCOME	B	-1,018	EMERGENCY	91.00	0 41.00
41.01	PROVIDER MEDICAID ASSESSMENT	A	-1,326,721	ADMINISTRATIVE & GENERAL	5.00	0 41.01
42.00	LOBBYING PORTION OF DUES	A	-14,796	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00	LOBBYING PORTION OF DUES	A	-1,917	ADMINISTRATIVE & GENERAL	5.00	0 43.00
44.00	PROPERTY TAX	A	-1,636	ADMINISTRATIVE & GENERAL	5.00	0 44.00
44.01	PROPERTY TAX	A	-4,670	ADMINISTRATIVE & GENERAL	5.00	0 44.01
44.02	PROPERTY TAX	A	-9,293	PHYSICIANS PRIVATE OFFICES	192.00	0 44.02
44.03	DEPRECIATION TO MEDICRE STRAIGHTLINE	A	212,504	CAP REL COSTS-BLDG & FIXT	1.00	9 44.03
44.04	DEPRECIATION TO MEDICRE STRAIGHTLINE	A	-21,342	CAP REL COSTS-MVBLE EQUIP	2.00	9 44.04
44.05	CAPITALIZED DEPRECIATION INTEREST	A	-464	CAP REL COSTS-BLDG & FIXT	1.00	9 44.05
44.06	NON-ALLOWABLE DEPRECIATION	A	-2,259	CAP REL COSTS-BLDG & FIXT	1.00	9 44.06
44.07	NON-ALLOWABLE DEPRECIATION	A	-7,304	CAP REL COSTS-MVBLE EQUIP	2.00	9 44.07
44.08	CONTRIBUTIONS	A	-8,000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00	0 44.08
44.09	SCHOLARSHIPS	A	0	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00	0 44.09
44.10	COMMUNITY SUPPORT	A	-6,641	ADMINISTRATIVE & GENERAL	5.00	0 44.10
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.00
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.01
45.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.02
45.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.03
45.04	PHYSICIAN MALPRACTICE	A	-1	ADMINISTRATIVE & GENERAL	5.00	0 45.04
45.05	SALES TAX EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	0 45.05
45.06	NON-ALLOWABLE MISC EXPENSE	A	-569	ADMINISTRATIVE & GENERAL	5.00	0 45.06
45.07	NON-ALLOWABLE MISC EXPENSE	A	-60	NURSING ADMINISTRATION	13.00	0 45.07
45.08	NON-ALLOWABLE MISC EXPENSE	A	-500	RADIOLOGY-DIAGNOSTIC	54.00	0 45.08
45.09	NON-ALLOWABLE MISC EXPENSE	A	-8,100	ADULTS & PEDIATRICS	30.00	0 45.09
45.10	NON-ALLOWABLE MISC EXPENSE	A	-527	LABORATORY	60.00	0 45.10
45.11	IC SUBSIDY	A	-2,746,715	ADMINISTRATIVE & GENERAL	5.00	0 45.11
45.12	OTHER COMMUNITY PROGRAM COSTS	A	-29,974	O/P PHYSICAL THERAPY	66.01	0 45.12
45.13	OTHER COMMUNITY PROGRAM COSTS	A	-4,951	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.13
45.14	AMBULANCE COSTS	A	-6,752	SOCIAL SERVICE	17.00	0 45.14
45.15	VACANT PROPERTY EXPENSE	A	-11,621	ADMINISTRATIVE & GENERAL	5.00	0 45.15
45.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.16
45.17	NONALLOWABLE MARKETING & PROMOTION	A	-246	NURSING ADMINISTRATION	13.00	0 45.17
45.18	NONALLOWABLE MARKETING & PROMOTION	A	-78	ADULTS & PEDIATRICS	30.00	0 45.18
45.19	NONALLOWABLE MARKETING & PROMOTION	A	-375	RADIOLOGY-DIAGNOSTIC	54.00	0 45.19
45.20	NONALLOWABLE MARKETING & PROMOTION	A	-78	EMERGENCY	91.00	0 45.20
45.21	NON VALLEY WEST COST	A	-3,162	PHYSICIANS PRIVATE OFFICES	192.00	0 45.21
45.22	NON VALLEY WEST COST	A	-10,000	PHYSICIANS PRIVATE OFFICES	192.00	0 45.22
45.23	NON VALLEY WEST COST	A	-3,000	PHYSICIANS PRIVATE OFFICES	192.00	0 45.23
45.24	NONALLOWABLE MARKETING & PROMOTION	A	0	OPERATION OF PLANT	7.00	0 45.24
45.25	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0 45.25
45.26	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0 45.26

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/25/2022 1:43 pm

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	
45.27	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.27
45.28	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.28
45.29	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.29
45.30	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.30
45.31	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.31
45.32	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.32
45.33	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.33
45.34	NONALLOWABLE MARKETING & PROMOTION	A	0		0.00	0	45.34
45.35	NON VALLEY WEST COST	A	0	PHYSICIANS PRIVATE OFFICES	192.00	0	45.35
45.36	NONALLOWABLE SPONSORSHIP A&G COST	A	0	PHYSICIANS PRIVATE OFFICES	192.00	0	45.36
45.37	NON VALLEY WEST COST	A	0	PHYSICIANS PRIVATE OFFICES	192.00	0	45.37
45.38	NON VALLEY WEST COST	A	0	PHYSICIANS PRIVATE OFFICES	192.00	0	45.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,509,537				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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/25/2022 1:43 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	NMHC HOME OFFICE ADMINISTRAT	5,785,182	9,741,915	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	NMHC HOME OFFICE EMPLOYEE BE	2,371,423	2,396,381	2.00
3.00	13.00	NURSING ADMINISTRATION	NMHC HOME OFFICE QUALITY	103,367	0	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	NMHC HOME OFFICE MEDICAL REC	3,137	0	4.00
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,263,109	12,138,296	5.00

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

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

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

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

6.00	B		100.00	NMHC	100.00	6.00
7.00	B		100.00	CDH	100.00	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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/25/2022 1:43 pm

	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	-3,956,733	0		1.00
2.00	-24,958	0		2.00
3.00	103,367	0		3.00
4.00	3,137	0		4.00
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
5.00	-3,875,187			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	HOME OFFICE		6.00
7.00	HEALTHCARE		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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-2

Date/Time Prepared:
1/25/2022 1:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	650,985	649,860	1,125	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	135,333	135,333	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	542,832	524,112	18,720	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	33,498	33,498	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	42,275	42,275	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	30,000	0	30,000	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	40,008	40,008	0	0	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	6,871	6,871	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00	AGGREGATE-	0	0	0	0	0	10.00
11.00	0.00	AGGREGATE-	0	0	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	0.00	AGGREGATE-	0	0	0	0	0	13.00
14.00	0.00	AGGREGATE-	0	0	0	0	0	14.00
15.00	0.00	AGGREGATE-	0	0	0	0	0	15.00
200.00			1,481,802	1,431,957	49,845			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00	AGGREGATE-	0	0	0	0	0	10.00
11.00	0.00	AGGREGATE-	0	0	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	0.00	AGGREGATE-	0	0	0	0	0	13.00
14.00	0.00	AGGREGATE-	0	0	0	0	0	14.00
15.00	0.00	AGGREGATE-	0	0	0	0	0	15.00
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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	649,860		1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	135,333		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	524,112		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	33,498		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	42,275		5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	40,008		7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	6,871		8.00
9.00	0.00	AGGREGATE-	0	0	0	0		9.00
10.00	0.00	AGGREGATE-	0	0	0	0		10.00
11.00	0.00	AGGREGATE-	0	0	0	0		11.00
12.00	0.00	AGGREGATE-	0	0	0	0		12.00
13.00	0.00	AGGREGATE-	0	0	0	0		13.00
14.00	0.00	AGGREGATE-	0	0	0	0		14.00
15.00	0.00	AGGREGATE-	0	0	0	0		15.00
200.00			0	0	0	1,431,957		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,527,011	1,527,011			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	422,955	422,955			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,637,096	8,668	2,401	2,648,165	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,933,065	142,170	39,379	198,868	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,326,051	229,464	63,557	55,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,780	14,086	3,902	0	8.00
9.00	00900	HOUSEKEEPING	549,385	21,269	5,891	60,175	9.00
10.00	01000	DIETARY	326,343	30,461	8,437	46,247	10.00
11.00	01100	CAFETERIA	263,072	19,276	5,339	40,930	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	466,370	3,985	1,104	60,396	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,110	56,361	15,611	9,661	14.00
15.00	01500	PHARMACY	543,210	20,238	5,605	96,620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,137	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	165,012	2,377	658	27,863	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,099,724	257,689	71,376	514,437	30.00
31.00	03100	INTENSIVE CARE UNIT	10,846	38,535	10,674	2,141	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	344,136	14,575	4,037	60,681	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,821,854	202,044	55,963	270,675	50.00
51.00	05100	RECOVERY ROOM	137,519	31,807	8,810	24,466	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	532,608	14,767	4,090	56,139	52.00
53.00	05300	ANESTHESIOLOGY	22,528	6,449	1,786	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,007,019	147,710	40,913	272,867	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	230,575	0	0	15,482	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,093,801	48,951	13,559	173,850	60.00
64.00	06400	INTRAVENOUS THERAPY	183,661	0	0	32,878	64.00
65.00	06500	RESPIRATORY THERAPY	570,394	11,412	3,161	103,365	65.00
66.00	06600	PHYSICAL THERAPY	484,852	10,311	2,856	81,261	66.00
66.01	06601	O/P PHYSICAL THERAPY	534,029	0	0	83,238	66.01
69.00	06900	ELECTROCARDIOLOGY	41,718	4,474	1,239	7,512	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,201,195	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	290,092	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,452	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	1,764,889	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	15,823	1,660	460	0	74.00
76.00	03020	CLINICAL NUTRITION	451	0	0	87	76.00
76.01	03950	SLEEP LAB	31,001	15,030	4,163	0	76.01
76.97	07697	CARDIAC REHABILITATION	161,970	19,958	5,528	29,249	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	70,728	0	0	6,537	90.00
91.00	09100	EMERGENCY	1,825,873	98,339	27,238	317,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,978,335	1,472,066	407,737	2,648,077	35,908,084	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	-1,716	19,696	5,455	0	23,435	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	558,397	6,326	1,752	0	566,475	192.00
194.00	07950	COMMUNITY WELLNESS	449	28,923	8,011	88	37,471	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,535,465	1,527,011	422,955	2,648,165	36,535,465	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B
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1/25/2022 1:43 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	8,313,482					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	787,804	0	3,462,178			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,692	0	42,529	194,989		8.00
9.00	00900	HOUSEKEEPING	187,562	0	64,215	0	888,497	9.00
10.00	01000	DIETARY	121,214	0	91,969	0	24,353	10.00
11.00	01100	CAFETERIA	96,802	0	58,200	0	15,411	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	156,671	0	12,030	0	3,186	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,056	0	170,167	0	45,059	14.00
15.00	01500	PHARMACY	196,091	0	61,102	0	16,179	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	924	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	57,710	0	7,176	0	1,900	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,161,570	0	778,021	57,589	206,014	30.00
31.00	03100	INTENSIVE CARE UNIT	18,321	0	116,347	234	30,808	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	124,732	0	44,006	6,283	11,653	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	986,984	0	610,017	25,926	161,528	50.00
51.00	05100	RECOVERY ROOM	59,681	0	96,032	0	25,429	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,985	0	44,586	2,739	11,806	52.00
53.00	05300	ANESTHESIOLOGY	9,062	0	19,470	1,701	5,156	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	727,161	0	445,970	25,544	118,090	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	72,482	0	0	237	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	686,407	0	147,795	0	39,135	60.00
64.00	06400	INTRAVENOUS THERAPY	63,787	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	202,765	0	34,456	240	9,124	65.00
66.00	06600	PHYSICAL THERAPY	170,641	0	31,131	0	8,243	66.00
66.01	06601	O/P PHYSICAL THERAPY	181,831	0	0	6,000	0	66.01
69.00	06900	ELECTROCARDIOLOGY	16,185	0	13,508	214	3,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	353,842	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	85,454	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,265	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	519,892	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	5,286	0	5,013	0	1,327	74.00
76.00	03020	CLINICAL NUTRITION	158	0	0	0	0	76.00
76.01	03950	SLEEP LAB	14,786	0	45,378	1,346	12,016	76.01
76.97	07697	CARDIAC REHABILITATION	63,836	0	60,258	144	15,956	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	22,760	0	0	151	0	90.00
91.00	09100	EMERGENCY	668,273	0	296,909	66,641	78,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,128,672	0	3,296,285	194,989	844,570	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	6,903	0	59,466	0	15,746	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	166,869	0	19,101	0	5,058	192.00
194.00	07950	COMMUNITY WELLNESS	11,038	0	87,326	0	23,123	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,313,482	0	3,462,178	194,989	888,497	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	649,024					10.00
11.00	01100	CAFETERIA	0	499,030				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	10,776	0	714,518		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,411	0	0	425,436	14.00
15.00	01500	PHARMACY	0	16,778	0	0	2,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	75	0	0	203	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	645,555	119,108	0	286,121	31,308	30.00
31.00	03100	INTENSIVE CARE UNIT	3,469	505	0	1,251	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	12,901	0	26,746	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	56,850	0	140,898	42,822	50.00
51.00	05100	RECOVERY ROOM	0	3,677	0	9,202	555	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,869	0	38,683	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,901	0	0	8,512	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,814	0	0	4,525	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	46,647	0	0	27,436	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,714	64.00
65.00	06500	RESPIRATORY THERAPY	0	22,740	0	0	304	65.00
66.00	06600	PHYSICAL THERAPY	0	21,443	0	0	617	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	18,672	0	0	434	66.01
69.00	06900	ELECTROCARDIOLOGY	0	1,655	0	4,101	64	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	193,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	71,725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	21	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	7,450	0	0	71	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,660	0	4,114	67	90.00
91.00	09100	EMERGENCY	0	82,070	0	203,402	33,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	649,024	499,023	0	714,518	425,431	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	5	192.00
194.00	07950	COMMUNITY WELLNESS	0	7	0	0	0	194.00
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)	649,024	499,030	0	714,518	425,436	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	958,522					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,061				16.00
17.00	01700	SOCIAL SERVICE	0	0	262,974			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	306	261,568	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2	1,406	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	17	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	340	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	21	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	73	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,001	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	253	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	429	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	87	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	70	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	39	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	59	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	4	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	194	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	49	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,880	402	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	878,642	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	1	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	1	0	0	0	76.00
76.01	03950	SLEEP LAB	0	9	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	15	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	7	0	0	0	90.00
91.00	09100	EMERGENCY	0	657	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	958,522	4,061	262,974	0	0	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	0	0	194.00
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)	958,522	4,061	262,974	0		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
			23.00	24.00	25.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	7,490,386	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	234,539	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	649,767	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,375,901	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	397,199	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	894,297	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	69,649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,853,688	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	327,368	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	3,278,010	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	284,127	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	958,031	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	811,394	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	0	824,263	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	94,251	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,749,061	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	447,320	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	287,999	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	3,163,423	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	29,570	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	718	0	76.00
76.01	03950	SLEEP LAB	0	0	0	123,729	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	364,435	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	106,024	0	90.00
91.00	09100	EMERGENCY	0	0	0	3,698,293	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	35,513,442	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	105,550	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	757,508	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	158,965	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	36,535,465	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING PROGRAM		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	7,490,386	30.00
31.00	03100	INTENSIVE CARE UNIT	234,539	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	649,767	43.00
45.00	04500	NURSING FACILITY	0	45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,375,901	50.00
51.00	05100	RECOVERY ROOM	397,199	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	894,297	52.00
53.00	05300	ANESTHESIOLOGY	69,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,853,688	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	327,368	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	3,278,010	60.00
64.00	06400	INTRAVENOUS THERAPY	284,127	64.00
65.00	06500	RESPIRATORY THERAPY	958,031	65.00
66.00	06600	PHYSICAL THERAPY	811,394	66.00
66.01	06601	O/P PHYSICAL THERAPY	824,263	66.01
69.00	06900	ELECTROCARDIOLOGY	94,251	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,749,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	447,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,999	73.00
73.01	07301	INJECTABLE DRUGS	3,163,423	73.01
74.00	07400	RENAL DIALYSIS	29,570	74.00
76.00	03020	CLINICAL NUTRITION	718	76.00
76.01	03950	SLEEP LAB	123,729	76.01
76.97	07697	CARDIAC REHABILITATION	364,435	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	106,024	90.00
91.00	09100	EMERGENCY	3,698,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OPT	0	99.20
99.30	09930	OOT	0	99.30
99.40	09940	OSP	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,513,442	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	105,550	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	757,508	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Total	
			26.00	
194.00	07950	COMMUNITY WELLNESS	158,965	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,535,465	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,668	2,401	11,069	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	848,462	142,170	39,379	1,030,011	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	229,464	63,557	293,021	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,086	3,902	17,988	8.00
9.00	00900	HOUSEKEEPING	0	21,269	5,891	27,160	9.00
10.00	01000	DIETARY	1,359	30,461	8,437	40,257	10.00
11.00	01100	CAFETERIA	4,416	19,276	5,339	29,031	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,985	1,104	5,089	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	56,361	15,611	71,972	14.00
15.00	01500	PHARMACY	60,648	20,238	5,605	86,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,377	658	3,035	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,419	257,689	71,376	349,484	30.00
31.00	03100	INTENSIVE CARE UNIT	0	38,535	10,674	49,209	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	14,575	4,037	18,612	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	202,044	55,963	258,007	50.00
51.00	05100	RECOVERY ROOM	0	31,807	8,810	40,617	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,767	4,090	18,857	52.00
53.00	05300	ANESTHESIOLOGY	0	6,449	1,786	8,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	147,710	40,913	188,623	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	83,341	0	0	83,341	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	48,951	13,559	62,510	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	660	11,412	3,161	15,233	65.00
66.00	06600	PHYSICAL THERAPY	0	10,311	2,856	13,167	66.00
66.01	06601	O/P PHYSICAL THERAPY	59,146	0	0	59,146	66.01
69.00	06900	ELECTROCARDIOLOGY	0	4,474	1,239	5,713	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	1,660	460	2,120	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	15,030	4,163	19,193	76.01
76.97	07697	CARDIAC REHABILITATION	0	19,958	5,528	25,486	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	15,043	0	0	15,043	90.00
91.00	09100	EMERGENCY	0	98,339	27,238	125,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,093,494	1,472,066	407,737	2,973,297	11,069	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	19,696	5,455	25,151	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	341,264	6,326	1,752	349,342	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	28,923	8,011	36,934	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,434,758	1,527,011	422,955	3,384,724	11,069	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	1,030,843					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	97,684	0	390,936			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,302	0	4,802	27,092		8.00
9.00	00900	HOUSEKEEPING	23,257	0	7,251	0	57,920	9.00
10.00	01000	DIETARY	15,030	0	10,385	0	1,588	10.00
11.00	01100	CAFETERIA	12,003	0	6,572	0	1,005	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	19,427	0	1,358	0	208	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,835	0	19,215	0	2,937	14.00
15.00	01500	PHARMACY	24,314	0	6,899	0	1,055	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	7,156	0	810	0	124	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	144,037	0	87,850	8,001	13,429	30.00
31.00	03100	INTENSIVE CARE UNIT	2,272	0	13,137	32	2,008	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	15,466	0	4,969	873	760	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	122,382	0	68,881	3,602	10,530	50.00
51.00	05100	RECOVERY ROOM	7,400	0	10,844	0	1,658	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,193	0	5,035	381	770	52.00
53.00	05300	ANESTHESIOLOGY	1,124	0	2,199	236	336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,165	0	50,357	3,549	7,698	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,987	0	0	33	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	85,111	0	16,688	0	2,551	60.00
64.00	06400	INTRAVENOUS THERAPY	7,909	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,142	0	3,891	33	595	65.00
66.00	06600	PHYSICAL THERAPY	21,159	0	3,515	0	537	66.00
66.01	06601	O/P PHYSICAL THERAPY	22,546	0	0	834	0	66.01
69.00	06900	ELECTROCARDIOLOGY	2,007	0	1,525	30	233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,875	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,596	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,861	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	64,464	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	655	0	566	0	87	74.00
76.00	03020	CLINICAL NUTRITION	20	0	0	0	0	76.00
76.01	03950	SLEEP LAB	1,833	0	5,124	187	783	76.01
76.97	07697	CARDIAC REHABILITATION	7,915	0	6,804	20	1,040	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,822	0	0	21	0	90.00
91.00	09100	EMERGENCY	82,863	0	33,526	9,260	5,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,007,927	0	372,203	27,092	55,057	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	856	0	6,715	0	1,026	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	20,691	0	2,157	0	330	192.00
194.00	07950	COMMUNITY WELLNESS	1,369	0	9,861	0	1,507	194.00
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)	1,030,843	0	390,936	27,092	57,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	67,453					10.00
11.00	01100	CAFETERIA	0	48,782				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,053	0	27,388		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	333	0	0	100,332	14.00
15.00	01500	PHARMACY	0	1,640	0	0	637	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7	0	0	48	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,092	11,645	0	10,966	7,384	30.00
31.00	03100	INTENSIVE CARE UNIT	361	49	0	48	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,261	0	1,025	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,557	0	5,401	10,099	50.00
51.00	05100	RECOVERY ROOM	0	359	0	353	131	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	965	0	1,483	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,758	0	0	2,008	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	373	0	0	1,067	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,560	0	0	6,470	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	876	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,223	0	0	72	65.00
66.00	06600	PHYSICAL THERAPY	0	2,096	0	0	146	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	1,825	0	0	102	66.01
69.00	06900	ELECTROCARDIOLOGY	0	162	0	157	15	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	45,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	16,915	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	2	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	728	0	0	17	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	162	0	158	16	90.00
91.00	09100	EMERGENCY	0	8,023	0	7,797	7,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,453	48,781	0	27,388	100,331	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	1	192.00
194.00	07950	COMMUNITY WELLNESS	0	1	0	0	0	194.00
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)	67,453	48,782	0	27,388	100,332	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	121,440					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	115				16.00
17.00	01700	SOCIAL SERVICE	0	0	11,297			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9	11,237			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	60			31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0			41.00
42.00	04200	SUBPROVIDER	0	0	0			42.00
43.00	04300	NURSERY	0	0	0			43.00
45.00	04500	NURSING FACILITY	0	0	0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10	0			50.00
51.00	05100	RECOVERY ROOM	0	1	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1	0			52.00
53.00	05300	ANESTHESIOLOGY	0	2	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7	0			55.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0			59.00
60.00	06000	LABORATORY	0	12	0			60.00
64.00	06400	INTRAVENOUS THERAPY	0	2	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	2	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1	0			66.00
66.01	06601	O/P PHYSICAL THERAPY	0	2	0			66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,121	11	0			73.00
73.01	07301	INJECTABLE DRUGS	111,319	0	0			73.01
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03020	CLINICAL NUTRITION	0	0	0			76.00
76.01	03950	SLEEP LAB	0	0	0			76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0			90.00
91.00	09100	EMERGENCY	0	19	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
99.30	09930	OOT	0	0	0			99.30
99.40	09940	OSP	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,440	115	11,297	0	0	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	121,440	115	11,297	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				713,282	0	30.00
31.00	03100	INTENSIVE CARE UNIT				67,185	0	31.00
41.00	04100	SUBPROVIDER - IRF				0	0	41.00
42.00	04200	SUBPROVIDER				0	0	42.00
43.00	04300	NURSERY				43,220	0	43.00
45.00	04500	NURSING FACILITY				0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				485,601	0	50.00
51.00	05100	RECOVERY ROOM				61,465	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				49,920	0	52.00
53.00	05300	ANESTHESIOLOGY				12,939	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				349,328	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				93,873	0	55.00
57.00	05700	CT SCAN				0	0	57.00
58.00	05800	MRI				0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				0	0	59.00
60.00	06000	LABORATORY				178,629	0	60.00
64.00	06400	INTRAVENOUS THERAPY				8,924	0	64.00
65.00	06500	RESPIRATORY THERAPY				47,623	0	65.00
66.00	06600	PHYSICAL THERAPY				40,961	0	66.00
66.01	06601	O/P PHYSICAL THERAPY				84,803	0	66.01
69.00	06900	ELECTROCARDIOLOGY				9,873	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				89,591	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				27,512	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				15,993	0	73.00
73.01	07301	INJECTABLE DRUGS				175,783	0	73.01
74.00	07400	RENAL DIALYSIS				3,428	0	74.00
76.00	03020	CLINICAL NUTRITION				22	0	76.00
76.01	03950	SLEEP LAB				27,120	0	76.01
76.97	07697	CARDIAC REHABILITATION				42,132	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				0	0	89.00
90.00	09000	CLINIC				18,249	0	90.00
91.00	09100	EMERGENCY				281,327	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OPT				0	0	99.20
99.30	09930	OOT				0	0	99.30
99.40	09940	OSP				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION				0	0	109.00
110.00	11000	INTESTINAL ACQUISITION				0	0	110.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
111.00	11100	ISLET ACQUISITION				0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	2,928,783	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				33,748	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES				372,521	0	192.00
194.00	07950	COMMUNITY WELLNESS				49,672	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	3,384,724	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B
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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING PROGRAM		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	713,282	30.00
31.00	03100	INTENSIVE CARE UNIT	67,185	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	43,220	43.00
45.00	04500	NURSING FACILITY	0	45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	485,601	50.00
51.00	05100	RECOVERY ROOM	61,465	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,920	52.00
53.00	05300	ANESTHESIOLOGY	12,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	349,328	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	93,873	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	178,629	60.00
64.00	06400	INTRAVENOUS THERAPY	8,924	64.00
65.00	06500	RESPIRATORY THERAPY	47,623	65.00
66.00	06600	PHYSICAL THERAPY	40,961	66.00
66.01	06601	O/P PHYSICAL THERAPY	84,803	66.01
69.00	06900	ELECTROCARDIOLOGY	9,873	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,512	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,993	73.00
73.01	07301	INJECTABLE DRUGS	175,783	73.01
74.00	07400	RENAL DIALYSIS	3,428	74.00
76.00	03020	CLINICAL NUTRITION	22	76.00
76.01	03950	SLEEP LAB	27,120	76.01
76.97	07697	CARDIAC REHABILITATION	42,132	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	18,249	90.00
91.00	09100	EMERGENCY	281,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OPT	0	99.20
99.30	09930	OOT	0	99.30
99.40	09940	OSP	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,928,783	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	33,748	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	372,521	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

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Cost Center Description			Total	
			26.00	
194.00	07950	COMMUNITY WELLNESS	49,672	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,384,724	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,376				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		87,376			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	496	496	13,555,143		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,135	8,135	1,017,946	-8,313,482	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,130	13,130	283,072	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	806	806	0	0	8.00
9.00	00900	HOUSEKEEPING	1,217	1,217	308,020	0	9.00
10.00	01000	DIETARY	1,743	1,743	236,724	0	10.00
11.00	01100	CAFETERIA	1,103	1,103	209,507	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	228	228	309,151	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,225	3,225	49,450	0	14.00
15.00	01500	PHARMACY	1,158	1,158	494,571	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	136	136	142,620	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,745	14,745	2,633,224	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,205	2,205	10,960	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	834	834	310,608	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,561	11,561	1,385,507	0	50.00
51.00	05100	RECOVERY ROOM	1,820	1,820	125,233	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	845	845	287,360	0	52.00
53.00	05300	ANESTHESIOLOGY	369	369	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,452	8,452	1,396,723	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	79,246	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,801	2,801	889,885	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	168,293	0	64.00
65.00	06500	RESPIRATORY THERAPY	653	653	529,097	0	65.00
66.00	06600	PHYSICAL THERAPY	590	590	415,951	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	426,072	0	66.01
69.00	06900	ELECTROCARDIOLOGY	256	256	38,450	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	95	95	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	445	0	76.00
76.01	03950	SLEEP LAB	860	860	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,142	1,142	149,719	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	33,463	0	90.00
91.00	09100	EMERGENCY	5,627	5,627	1,623,397	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				2,268,600	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,232	84,232	13,554,694	-8,313,482	27,594,602	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,127	1,127	0	0	23,435	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	362	362	0	0	566,475	192.00
194.00	07950	COMMUNITY WELLNESS	1,655	1,655	449	0	37,471	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,527,011	422,955	2,648,165		8,313,482	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.476321	4.840631	0.195362		0.294575	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,069		1,030,843	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000817		0.036526	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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	65,615				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	806	120,111			8.00
9.00	00900	HOUSEKEEPING	0	1,217	0	63,592		9.00
10.00	01000	DIETARY	0	1,743	0	1,743	2,245	10.00
11.00	01100	CAFETERIA	0	1,103	0	1,103	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	228	0	228	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,225	0	3,225	0	14.00
15.00	01500	PHARMACY	0	1,158	0	1,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	136	0	136	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	14,745	35,474	14,745	2,233	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,205	144	2,205	12	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	834	3,870	834	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,561	15,970	11,561	0	50.00
51.00	05100	RECOVERY ROOM	0	1,820	0	1,820	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	845	1,687	845	0	52.00
53.00	05300	ANESTHESIOLOGY	0	369	1,048	369	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,452	15,735	8,452	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	146	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,801	0	2,801	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	653	148	653	0	65.00
66.00	06600	PHYSICAL THERAPY	0	590	0	590	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	3,696	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	256	132	256	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	95	0	95	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	860	829	860	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,142	89	1,142	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	93	0	0	90.00
91.00	09100	EMERGENCY	0	5,627	41,050	5,627	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	62,471	120,111	60,448	2,245	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
		6.00	7.00	8.00	9.00	10.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,127	0	1,127	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	362	0	362	0 192.00
194.00	07950	COMMUNITY WELLNESS	0	1,655	0	1,655	0 194.00
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)	0	3,462,178	194,989	888,497	649,024 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	52.765038	1.623407	13.971836	289.097550 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	390,936	27,092	57,920	67,453 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.958028	0.225558	0.910806	30.045880 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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	280,782					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	6,063	0	162,212			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,919	0	0	1,405,589		14.00
15.00	01500	PHARMACY	9,440	0	0	8,918	1,925,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	42	0	0	671	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,017	0	64,956	103,438	0	30.00
31.00	03100	INTENSIVE CARE UNIT	284	0	284	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	7,259	0	6,072	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,987	0	31,987	141,480	0	50.00
51.00	05100	RECOVERY ROOM	2,069	0	2,089	1,834	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,553	0	8,782	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,311	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,141	0	0	28,124	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,146	0	0	14,951	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	26,246	0	0	90,646	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,269	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,795	0	0	1,006	0	65.00
66.00	06600	PHYSICAL THERAPY	12,065	0	0	2,039	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	10,506	0	0	1,435	0	66.01
69.00	06900	ELECTROCARDIOLOGY	931	0	931	213	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	640,388	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	236,969	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	160,452	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	1,764,889	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	12	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	4,192	0	0	233	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	934	0	934	222	0	90.00
91.00	09100	EMERGENCY	46,177	0	46,177	109,427	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	280,778	0	162,212	1,405,574	1,925,341	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	15	0	192.00
194.00	07950	COMMUNITY WELLNESS	4	0	0	0	0	194.00
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)	499,030	0	714,518	425,436	958,522	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.777286	0.000000	4.404841	0.302675	0.497845	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,782	0	27,388	100,332	121,440	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.173736	0.000000	0.168841	0.071381	0.063075	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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,844,663					16.00
17.00	01700	SOCIAL SERVICE	0	2,245				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,744,399	2,233	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	55,239	12	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	482,000	0	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,720,446	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	589,937	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	727,305	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,089,959	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,508,477	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,219,219	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,258,236	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,485,912	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,993,529	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,101,732	0	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	1,694,385	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	108,275	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,530,993	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,400,116	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,472,380	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	18,225	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	24,709	0	0	0	0	76.00
76.01	03950	SLEEP LAB	247,840	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	416,189	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	188,517	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,766,644	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,844,663	2,245	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,061	262,974	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000035	117.137639	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	115	11,297	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000001	5.032071	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B-1
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	76.00
76.01	03950	SLEEP LAB	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OPT	0	0	99.20
99.30	09930	OOT	0	0	99.30
99.40	09940	OSP	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet B-1
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	194.00
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

			Title XVIII		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,490,386		7,490,386	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	234,539		234,539	0	0 31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0 41.00
42.00	04200	SUBPROVIDER	0		0	0	0 42.00
43.00	04300	NURSERY	649,767		649,767	0	0 43.00
45.00	04500	NURSING FACILITY	0		0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,375,901		5,375,901	0	0 50.00
51.00	05100	RECOVERY ROOM	397,199		397,199	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	894,297		894,297	0	0 52.00
53.00	05300	ANESTHESIOLOGY	69,649		69,649	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,853,688		3,853,688	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	327,368		327,368	0	0 55.00
57.00	05700	CT SCAN	0		0	0	0 57.00
58.00	05800	MRI	0		0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000	LABORATORY	3,278,010		3,278,010	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	284,127		284,127	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	958,031	0	958,031	0	0 65.00
66.00	06600	PHYSICAL THERAPY	811,394	0	811,394	0	0 66.00
66.01	06601	O/P PHYSICAL THERAPY	824,263	0	824,263	0	0 66.01
69.00	06900	ELECTROCARDIOLOGY	94,251		94,251	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,749,061		1,749,061	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	447,320		447,320	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,999		287,999	0	0 73.00
73.01	07301	INJECTABLE DRUGS	3,163,423		3,163,423	0	0 73.01
74.00	07400	RENAL DIALYSIS	29,570		29,570	0	0 74.00
76.00	03020	CLINICAL NUTRITION	718		718	0	0 76.00
76.01	03950	SLEEP LAB	123,729		123,729	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	364,435		364,435	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
90.00	09000	CLINIC	106,024		106,024	0	0 90.00
91.00	09100	EMERGENCY	3,698,293		3,698,293	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,609,730		1,609,730	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0		0 99.10
99.20	09920	OPT	0		0		0 99.20
99.30	09930	OOT	0		0		0 99.30
99.40	09940	OSP	0		0		0 99.40
101.00	10100	HOME HEALTH AGENCY	0		0		0 101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0		0 109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0 110.00
111.00	11100	ISLET ACQUISITION	0		0		0 111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	37,123,172	0	37,123,172	0	0 200.00
201.00		Less Observation Beds	1,609,730		1,609,730		0 201.00
202.00		Total (see instructions)	35,513,442	0	35,513,442	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

			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	4,661,544		4,661,544			30.00
31.00	03100	INTENSIVE CARE UNIT	53,782		53,782			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	462,585		462,585			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,422,676	9,001,717	10,424,393	0.515704	0.000000	50.00
51.00	05100	RECOVERY ROOM	335,907	1,076,261	1,412,168	0.281269	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	561,862	107,173	669,035	1.336697	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	792,867	2,057,571	2,850,438	0.024434	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,544,447	34,396,479	36,940,926	0.104320	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,660	880,169	884,829	0.369979	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,582,634	14,503,564	17,086,198	0.191851	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	206,773	3,311,738	3,518,511	0.080752	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	851,386	2,140,627	2,992,013	0.320196	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,091,820	2,730,779	3,822,599	0.212262	0.000000	66.00
66.01	06601	O/P PHYSICAL THERAPY	5,150	2,709,463	2,714,613	0.303639	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	1,089	127,767	128,856	0.731444	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,899,235	5,057,502	6,956,737	0.251420	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	314,244	1,541,992	1,856,236	0.240982	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,965,868	7,705,231	12,671,099	0.022729	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	856,287	9,160,563	10,016,850	0.315810	0.000000	73.01
74.00	07400	RENAL DIALYSIS	28,943	24,621	53,564	0.552050	0.000000	74.00
76.00	03020	CLINICAL NUTRITION	0	4,845	4,845	0.148194	0.000000	76.00
76.01	03950	SLEEP LAB	20,625	297,041	317,666	0.389494	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	690,680	690,680	0.527647	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	47,434	447,246	494,680	0.214328	0.000000	90.00
91.00	09100	EMERGENCY	513,803	16,678,271	17,192,074	0.215116	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	562,520	3,949,168	4,511,688	0.356791	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
99.30	09930	OOT	0	0	0			99.30
99.40	09940	OSP	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,788,141	118,600,468	143,388,609			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,788,141	118,600,468	143,388,609			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	O/P PHYSICAL THERAPY	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
73.01	07301	INJECTABLE DRUGS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	CLINICAL NUTRITION	0.000000		76.00
76.01	03950	SLEEP LAB	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OPT			99.20
99.30	09930	OOT			99.30
99.40	09940	OSP			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

			Title XIX		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,490,386		7,490,386	0	7,490,386
31.00	03100	INTENSIVE CARE UNIT	234,539		234,539	0	234,539
41.00	04100	SUBPROVIDER - IRF	0		0	0	0
42.00	04200	SUBPROVIDER	0		0	0	0
43.00	04300	NURSERY	649,767		649,767	0	649,767
45.00	04500	NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,375,901		5,375,901	0	5,375,901
51.00	05100	RECOVERY ROOM	397,199		397,199	0	397,199
52.00	05200	DELIVERY ROOM & LABOR ROOM	894,297		894,297	0	894,297
53.00	05300	ANESTHESIOLOGY	69,649		69,649	0	69,649
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,853,688		3,853,688	0	3,853,688
55.00	05500	RADIOLOGY-THERAPEUTIC	327,368		327,368	0	327,368
57.00	05700	CT SCAN	0		0	0	0
58.00	05800	MRI	0		0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	3,278,010		3,278,010	0	3,278,010
64.00	06400	INTRAVENOUS THERAPY	284,127		284,127	0	284,127
65.00	06500	RESPIRATORY THERAPY	958,031	0	958,031	0	958,031
66.00	06600	PHYSICAL THERAPY	811,394	0	811,394	0	811,394
66.01	06601	O/P PHYSICAL THERAPY	824,263	0	824,263	0	824,263
69.00	06900	ELECTROCARDIOLOGY	94,251		94,251	0	94,251
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,749,061		1,749,061	0	1,749,061
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	447,320		447,320	0	447,320
73.00	07300	DRUGS CHARGED TO PATIENTS	287,999		287,999	0	287,999
73.01	07301	INJECTABLE DRUGS	3,163,423		3,163,423	0	3,163,423
74.00	07400	RENAL DIALYSIS	29,570		29,570	0	29,570
76.00	03020	CLINICAL NUTRITION	718		718	0	718
76.01	03950	SLEEP LAB	123,729		123,729	0	123,729
76.97	07697	CARDIAC REHABILITATION	364,435		364,435	0	364,435
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000	CLINIC	106,024		106,024	0	106,024
91.00	09100	EMERGENCY	3,698,293		3,698,293	0	3,698,293
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,609,730		1,609,730	0	1,609,730
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0	0	0
99.20	09920	OPT	0		0	0	0
99.30	09930	OOT	0		0	0	0
99.40	09940	OSP	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0	0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0
111.00	11100	ISLET ACQUISITION	0		0	0	0
113.00	11300	INTEREST EXPENSE	0		0	0	0
200.00		Subtotal (see instructions)	37,123,172	0	37,123,172	0	37,123,172
201.00		Less Observation Beds	1,609,730		1,609,730	0	1,609,730
202.00		Total (see instructions)	35,513,442	0	35,513,442	0	35,513,442

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

			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	4,661,544		4,661,544			30.00
31.00	03100	INTENSIVE CARE UNIT	53,782		53,782			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	462,585		462,585			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,422,676	9,001,717	10,424,393	0.515704	0.000000	50.00
51.00	05100	RECOVERY ROOM	335,907	1,076,261	1,412,168	0.281269	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	561,862	107,173	669,035	1.336697	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	792,867	2,057,571	2,850,438	0.024434	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,544,447	34,396,479	36,940,926	0.104320	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,660	880,169	884,829	0.369979	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,582,634	14,503,564	17,086,198	0.191851	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	206,773	3,311,738	3,518,511	0.080752	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	851,386	2,140,627	2,992,013	0.320196	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,091,820	2,730,779	3,822,599	0.212262	0.000000	66.00
66.01	06601	O/P PHYSICAL THERAPY	5,150	2,709,463	2,714,613	0.303639	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	1,089	127,767	128,856	0.731444	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,899,235	5,057,502	6,956,737	0.251420	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	314,244	1,541,992	1,856,236	0.240982	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,965,868	7,705,231	12,671,099	0.022729	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	856,287	9,160,563	10,016,850	0.315810	0.000000	73.01
74.00	07400	RENAL DIALYSIS	28,943	24,621	53,564	0.552050	0.000000	74.00
76.00	03020	CLINICAL NUTRITION	0	4,845	4,845	0.148194	0.000000	76.00
76.01	03950	SLEEP LAB	20,625	297,041	317,666	0.389494	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	690,680	690,680	0.527647	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	47,434	447,246	494,680	0.214328	0.000000	90.00
91.00	09100	EMERGENCY	513,803	16,678,271	17,192,074	0.215116	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	562,520	3,949,168	4,511,688	0.356791	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
99.30	09930	OOT	0	0	0			99.30
99.40	09940	OSP	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,788,141	118,600,468	143,388,609			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,788,141	118,600,468	143,388,609			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	O/P PHYSICAL THERAPY	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
73.01	07301	INJECTABLE DRUGS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	CLINICAL NUTRITION	0.000000		76.00
76.01	03950	SLEEP LAB	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OPT			99.20
99.30	09930	OOT			99.30
99.40	09940	OSP			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part II
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			Title XVIII		Hospital	Cost		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	485,601	10,424,393	0.046583	300,860	14,015	50.00
51.00	05100	RECOVERY ROOM	61,465	1,412,168	0.043525	42,033	1,829	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,920	669,035	0.074615	3,759	280	52.00
53.00	05300	ANESTHESIOLOGY	12,939	2,850,438	0.004539	98,553	447	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	349,328	36,940,926	0.009456	775,032	7,329	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	93,873	884,829	0.106092	4,537	481	55.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	178,629	17,086,198	0.010455	749,732	7,838	60.00
64.00	06400	INTRAVENOUS THERAPY	8,924	3,518,511	0.002536	35,061	89	64.00
65.00	06500	RESPIRATORY THERAPY	47,623	2,992,013	0.015917	305,710	4,866	65.00
66.00	06600	PHYSICAL THERAPY	40,961	3,822,599	0.010715	248,483	2,662	66.00
66.01	06601	O/P PHYSICAL THERAPY	84,803	2,714,613	0.031239	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	9,873	128,856	0.076620	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,591	6,956,737	0.012878	533,000	6,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,512	1,856,236	0.014821	83,186	1,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,993	12,671,099	0.001262	1,816,238	2,292	73.00
73.01	07301	INJECTABLE DRUGS	175,783	10,016,850	0.017549	0	0	73.01
74.00	07400	RENAL DIALYSIS	3,428	53,564	0.063998	17,829	1,141	74.00
76.00	03020	CLINICAL NUTRITION	22	4,845	0.004541	0	0	76.00
76.01	03950	SLEEP LAB	27,120	317,666	0.085373	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	42,132	690,680	0.061001	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	18,249	494,680	0.036891	0	0	90.00
91.00	09100	EMERGENCY	281,327	17,192,074	0.016364	1,611	26	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	153,288	4,511,688	0.033976	88	3	92.00
200.00		Total (lines 50 through 199)	2,258,384	138,210,698		5,015,712	51,395	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	0	0	0 66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0 73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	0 76.00
76.01	03950	SLEEP LAB	0	0	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 1:43 pm

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	10,424,393	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	1,412,168	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	669,035	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	2,850,438	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,940,926	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	884,829	0.000000
57.00	05700	CT SCAN	0	0	0	0	0.000000
58.00	05800	MRI	0	0	0	0	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	17,086,198	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,518,511	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,992,013	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	3,822,599	0.000000
66.01	06601	O/P PHYSICAL THERAPY	0	0	0	2,714,613	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	128,856	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,956,737	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,856,236	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,671,099	0.000000
73.01	07301	INJECTABLE DRUGS	0	0	0	10,016,850	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	53,564	0.000000
76.00	03020	CLINICAL NUTRITION	0	0	0	4,845	0.000000
76.01	03950	SLEEP LAB	0	0	0	317,666	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	690,680	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000
90.00	09000	CLINIC	0	0	0	494,680	0.000000
91.00	09100	EMERGENCY	0	0	0	17,192,074	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,511,688	0.000000
200.00		Total (lines 50 through 199)	0	0	0	138,210,698	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 1:43 pm

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	300,860	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	42,033	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,759	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	98,553	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	775,032	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	4,537	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	749,732	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	35,061	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	305,710	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	248,483	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.000000	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	533,000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	83,186	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,816,238	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	17,829	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0.000000	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,611	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	88	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,015,712	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/25/2022 1:43 pm

			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	0.515704	0	2,800,904	0	0	50.00
51.00	05100	RECOVERY ROOM	0.281269	0	315,537	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.336697	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024434	0	562,802	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104320	0	11,381,111	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.369979	0	466,825	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.191851	0	4,797,448	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080752	0	456,391	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.320196	0	704,229	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.212262	0	755,662	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.303639	0	807,529	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.731444	0	46,200	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.251420	0	1,432,984	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240982	0	357,978	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.022729	0	212,786	360	0	73.00
73.01	07301	INJECTABLE DRUGS	0.315810	0	5,669,869	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.552050	0	17,983	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0.148194	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0.389494	0	69,377	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.527647	0	339,927	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.214328	0	121,444	78,892	0	90.00
91.00	09100	EMERGENCY	0.215116	0	4,930,862	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356791	0	1,359,899	0	0	92.00
200.00		Subtotal (see instructions)		0	37,607,747	79,252	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	37,607,747	79,252	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1340		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part V Date/Time Prepared: 1/25/2022 1:43 pm	
				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	1,444,437	0				50.00	
51.00	05100	RECOVERY ROOM	88,751	0				51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00	
53.00	05300	ANESTHESIOLOGY	13,752	0				53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,187,277	0				54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	172,715	0				55.00	
57.00	05700	CT SCAN	0	0				57.00	
58.00	05800	MRI	0	0				58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0				59.00	
60.00	06000	LABORATORY	920,395	0				60.00	
64.00	06400	INTRAVENOUS THERAPY	36,854	0				64.00	
65.00	06500	RESPIRATORY THERAPY	225,491	0				65.00	
66.00	06600	PHYSICAL THERAPY	160,398	0				66.00	
66.01	06601	O/P PHYSICAL THERAPY	245,197	0				66.01	
69.00	06900	ELECTROCARDIOLOGY	33,793	0				69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	360,281	0				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,266	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,836	8				73.00	
73.01	07301	INJECTABLE DRUGS	1,790,601	0				73.01	
74.00	07400	RENAL DIALYSIS	9,928	0				74.00	
76.00	03020	CLINICAL NUTRITION	0	0				76.00	
76.01	03950	SLEEP LAB	27,022	0				76.01	
76.97	07697	CARDIAC REHABILITATION	179,361	0				76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC						88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00	
90.00	09000	CLINIC	26,029	16,909				90.00	
91.00	09100	EMERGENCY	1,060,707	0				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	485,200	0				92.00	
200.00		Subtotal (see instructions)	8,559,291	16,917				200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202.00		Net Charges (line 200 - line 201)	8,559,291	16,917				202.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/25/2022 1:43 pm
Title XVIII		Hospital	Cost	
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,274	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,594	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,914	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	563	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	117	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	832	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)	184	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)	352	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	145.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	145.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)	7,490,386	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)	16,965	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00	
26.00	Total swing-bed cost (see instructions)	1,349,727	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,140,659	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)	6,140,659	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)	2,367.25	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,969,552	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)	1,969,552	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/25/2022 1:43 pm

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)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	234,539	7	33,505.57	4	134,022
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					759,793
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,863,367
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					435,574
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					833,272
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,268,846
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					680
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,367.25
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,609,730

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/25/2022 1:43 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	713,282	7,490,386	0.095226	1,609,730	153,288
91.00	Nursing Program cost	0	7,490,386	0.000000	1,609,730	0
92.00	Allied health cost	0	7,490,386	0.000000	1,609,730	0
93.00	All other Medical Education	0	7,490,386	0.000000	1,609,730	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/25/2022 1:43 pm
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		1,534,053	30.00
31.00	03100	INTENSIVE CARE UNIT		23,874	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.515704	300,860	155,155 50.00
51.00	05100	RECOVERY ROOM	0.281269	42,033	11,823 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.336697	3,759	5,025 52.00
53.00	05300	ANESTHESIOLOGY	0.024434	98,553	2,408 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104320	775,032	80,851 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.369979	4,537	1,679 55.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.191851	749,732	143,837 60.00
64.00	06400	INTRAVENOUS THERAPY	0.080752	35,061	2,831 64.00
65.00	06500	RESPIRATORY THERAPY	0.320196	305,710	97,887 65.00
66.00	06600	PHYSICAL THERAPY	0.212262	248,483	52,743 66.00
66.01	06601	O/P PHYSICAL THERAPY	0.303639	0	0 66.01
69.00	06900	ELECTROCARDIOLOGY	0.731444	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.251420	533,000	134,007 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240982	83,186	20,046 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.022729	1,816,238	41,281 73.00
73.01	07301	INJECTABLE DRUGS	0.315810	0	0 73.01
74.00	07400	RENAL DIALYSIS	0.552050	17,829	9,842 74.00
76.00	03020	CLINICAL NUTRITION	0.148194	0	0 76.00
76.01	03950	SLEEP LAB	0.389494	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0.527647	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.214328	0	0 90.00
91.00	09100	EMERGENCY	0.215116	1,611	347 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356791	88	31 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,015,712	759,793 200.00
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)		5,015,712	759,793 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1340 Component CCN: 14-Z340	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/25/2022 1:43 pm	
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.515704	6,340	3,270	50.00
51.00	05100	RECOVERY ROOM	0.281269	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.336697	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024434	1,080	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104320	59,174	6,173	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.369979	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.191851	84,702	16,250	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080752	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.320196	153,220	49,060	65.00
66.00	06600	PHYSICAL THERAPY	0.212262	632,048	134,160	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.303639	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.731444	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.251420	69,670	17,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240982	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.022729	298,940	6,795	73.00
73.01	07301	INJECTABLE DRUGS	0.315810	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.552050	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0.148194	0	0	76.00
76.01	03950	SLEEP LAB	0.389494	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.527647	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.214328	0	0	90.00
91.00	09100	EMERGENCY	0.215116	994	214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356791	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,306,168	233,464	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,306,168		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1340 Component CCN: 14-Z340	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/25/2022 1:43 pm	
Cost Center Description			Title XIX	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.515704	0	0	50.00
51.00	05100	RECOVERY ROOM	0.281269	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.336697	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024434	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104320	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.369979	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.191851	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080752	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.320196	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.212262	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.303639	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.731444	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.251420	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240982	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.022729	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0.315810	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.552050	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0.148194	0	0	76.00
76.01	03950	SLEEP LAB	0.389494	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.527647	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.214328	0	0	90.00
91.00	09100	EMERGENCY	0.215116	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356791	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part B Date/Time Prepared: 1/25/2022 1:43 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,576,208	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,576,208	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 charge basis 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)		8,661,970	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)		25,153	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,211,830	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)		2,424,987	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)		2,424,987	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,424,987	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)		496,872	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		322,967	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		90,345	36.00
37.00	Subtotal (see instructions)		2,747,954	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)		2,747,954	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		3,058,650	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)		-310,696	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: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part I
Date/Time Prepared:
1/25/2022 1:43 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,642,815		3,445,028	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	05/12/2021	19,220	05/12/2021	335,125	3.50
3.51		08/03/2021	6,868	08/03/2021	51,253	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)		-26,088		-386,378	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)		2,616,727		3,058,650	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		58,051		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		310,696	6.02
7.00	Total Medicare program liability (see instructions)		2,674,778		2,747,954	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1340

Period:

Worksheet E-1

Component CCN: 14-Z340

From 09/01/2020
To 08/31/2021Part I
Date/Time Prepared:
1/25/2022 1:43 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,766,103		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	05/12/2021	41,567		0	3.50
3.51		08/03/2021	8,963		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)		-50,530		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)		1,715,573		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		213,261		0	6.02
7.00	Total Medicare program liability (see instructions)		1,502,312		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part II
Date/Time Prepared:
1/25/2022 1:43 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1340 Component CCN: 14-Z340	Period: From 09/01/2020 To 08/31/2021	Worksheet E-2 Date/Time Prepared: 1/25/2022 1:43 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,281,534	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)		235,799	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		536	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)		1,517,333	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,517,333	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)		1,517,333	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		15,021	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,502,312	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)		1,502,312	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		1,715,573	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)		-213,261	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet E-2
		Component CCN: 14-Z340		Date/Time Prepared: 1/25/2022 1:43 pm
		Title XIX	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration		0	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	19.25
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1340	Period: From 09/01/2020 To 08/31/2021	Worksheet E-3 Part V Date/Time Prepared: 1/25/2022 1:43 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,863,367	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)		2,863,367	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,892,001	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)		2,892,001	19.00
20.00	Deductibles (exclude professional component)		264,272	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,627,729	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,627,729	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		72,383	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		47,049	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,907	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,674,778	28.00
29.00	SEQUESTRATION ADJUSTMENT		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,674,778	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		2,616,727	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)		58,051	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: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet G

Date/Time Prepared:
1/25/2022 1:43 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	65,120	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	14,503,785	0	0	0	4.00
5.00 Other receivable	1,412,779	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-9,053,093	0	0	0	6.00
7.00 Inventory	755,949	0	0	0	7.00
8.00 Prepaid expenses	71,233	0	0	0	8.00
9.00 Other current assets	35,019,327	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)	42,775,100	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,794,000	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	25,352,267	0	0	0	15.00
16.00 Accumulated depreciation	-10,121,658	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	7,455,010	0	0	0	23.00
24.00 Accumulated depreciation	-4,542,206	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)	19,937,413	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	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	62,712,513	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	632,143	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,446,802	0	0	0	38.00
39.00 Payroll taxes payable	104,766	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	7,946,469	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	10,130,180	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	10,130,180	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	52,582,333	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)	52,582,333	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	62,712,513	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-1

Date/Time Prepared:
1/25/2022 1:43 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,570,214		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,105,529				2.00
3.00	Total (sum of line 1 and line 2)		52,675,743		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)		52,675,743		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		52,675,740		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	ROUNDING		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: 14-1340

Period:
From 09/01/2020
To 08/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
1/25/2022 1:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,661,544		4,661,544	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,661,544		4,661,544	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	53,782		53,782	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)	53,782		53,782	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,715,326		4,715,326	17.00
18.00	Ancillary services	20,072,815	118,600,438	138,673,253	18.00
19.00	Outpatient services	0	6,085	6,085	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OPT	0	0	0	24.20
24.30	OOT	0	0	0	24.30
24.40	OSP	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES / OTHER	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,788,141	118,606,523	143,394,664	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46,045,002		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	BAD DEBTS	240,712			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)		240,712		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,804,290		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-3

Date/Time Prepared:
1/25/2022 1:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	143,394,664	1.00
2.00	Less contractual allowances and discounts on patients' accounts	86,625,831	2.00
3.00	Net patient revenues (line 1 minus line 2)	56,768,833	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,804,290	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,964,543	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	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	867,489	24.00
24.01	NON OPERATING	46,692	24.01
24.02	ROUNDING	26	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.50	COVID-19 PHE Funding	226,779	24.50
25.00	Total other income (sum of lines 6-24)	1,140,986	25.00
26.00	Total (line 5 plus line 25)	12,105,529	26.00
27.00	NON OPERATING	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,105,529	29.00