

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

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

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

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet S
Parts I-III
Date/Time Prepared:
7/12/2021 5:55 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/12/2021	Time: 5:55 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Sycamore (14-2006) for the cost reporting period beginning 09/01/2020 and ending 12/15/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Sr Vice President of Reimbursement
Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	132,094	0	0	121,643	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	132,094	0	0	121,643	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: 14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 5:55 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 225 Edward Street			PO Box:				1.00	
2.00	City: Sycamore			State: IL		Zip Code: 60178		County: DeKalb 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			Kindred Hospital Sycamore	142006	20994	2	01/01/1988	N P O 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2020	12/15/2020	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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

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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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-2
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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From 09/01/2020
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Part I
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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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			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
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 5:55 pm	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	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
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				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:	28,279	0	81,107	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				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.	N				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 5:55 pm				
		1.00	2.00					
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	HB1754	140.00				
		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: KINDRED HEALTHCARE OPERATING LLC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 05901	141.00				
142.00	Street: 680 SOUTH FOURTH STREET	PO Box:		142.00				
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202	143.00				
				1.00				
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00				
		1.00	2.00					
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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		
				1.00				
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00				
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03
				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.	N		167.00				
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00				
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01				
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00		169.00				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 5:55 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet S-2 Part II Date/Time Prepared: 7/12/2021 5:55 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/30/2021	Y	06/30/2021		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-2
Part II
Date/Time Prepared:
7/12/2021 5:55 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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	12/31/2020	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.	DAVID	SIMPSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967945	KindredReimbursement@kindred.com		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet S-2 Part II Date/Time Prepared: 7/12/2021 5:55 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part I
Date/Time Prepared:
7/12/2021 5:55 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 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	69	7,314	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		69	7,314	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		69	7,314	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		69				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: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part I
Date/Time Prepared:
7/12/2021 5:55 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)	1,094	263	3,361		1.00
2.00	HMO and other (see instructions)	359	585			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,094	263	3,361		7.00
8.00	INTENSIVE CARE UNIT	0	0	0		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,094	263	3,361	0.00	111.40
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC					25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	26.25
28.00	Observation Bed Days		0	0		0.00
29.00	Ambulance Trips	0				111.40
30.00	Employee discount days (see instruction)			0		28.00
31.00	Employee discount days - IRF			0		29.00
32.00	Labor & delivery days (see instructions)	0	0	0		30.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		31.00
33.00	LTCH non-covered days	0				32.00
33.01	LTCH site neutral days and discharges	0				32.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part I
Date/Time Prepared:
7/12/2021 5:55 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	50	6	127	1.00
2.00 HMO and other (see instructions)			17	26		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	50	6	127	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	2,368,080	0	2,368,080	67,747.83	34.95	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	-21.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	41,229	41,229	450.17	91.59	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		403,666	0	403,666	5,761.00	70.07	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		193,300	0	193,300	1,850.00	104.49	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		497,531	0	497,531	6,594.58	75.45	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		320,671	0	320,671			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		5,995	0	5,995			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	317,029	0	317,029	5,727.00	55.36	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	53,970	0	53,970	3,905.00	13.82	32.00
33.00	Housekeeping under contract (see instructions)		7,938	0	7,938	255.00	31.13	33.00
34.00	Dietary	10.00	79,112	0	79,112	4,301.00	18.39	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	206,200	0	206,200	4,186.00	49.26	38.00
39.00	Central Services and Supply	14.00	34,231	0	34,231	1,287.00	26.60	39.00
40.00	Pharmacy	15.00	141,516	0	141,516	3,660.00	38.67	40.00
41.00	Medical Records & Medical Records Library	16.00	78,003	0	78,003	2,070.00	37.68	41.00
42.00	Social Service	17.00	125,096	-41,229	83,867	1,494.83	56.10	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part III
Date/Time Prepared:
7/12/2021 5:55 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	2,376,018	0	2,376,018	68,002.83	34.94	1.00
2.00	Excluded area salaries (see instructions)	0	41,229	41,229	429.17	96.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	2,376,018	-41,229	2,334,789	67,573.66	34.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,094,497	0	1,094,497	14,205.58	77.05	4.00
5.00	Subtotal wage-related costs (see inst.)	320,671	0	320,671	0.00	13.73	5.00
6.00	Total (sum of lines 3 thru 5)	3,791,186	-41,229	3,749,957	81,779.24	45.85	6.00
7.00	Total overhead cost (see instructions)	1,043,095	-41,229	1,001,866	26,885.83	37.26	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet S-3 Part IV Date/Time Prepared: 7/12/2021 5:55 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		3,168	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		116,899	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-3,632	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		1,122	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		13,635	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		25,423	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		158,692	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		4,366	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		999	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		320,672	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet S-3
Part V
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	403,666	320,671	1.00
2.00	Hospital	403,666	320,671	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet A Date/Time Prepared: 7/12/2021 5:55 pm							
		Cost Center Description		Salaries		Other		Total (col. 1 + col. 2)		Reclassificat ions (See A-6)		Reclassified Trial Balance (col. 3 +- col. 4)			
				1.00		2.00		3.00		4.00		5.00			
GENERAL SERVICE COST CENTERS															
1.00	00100	CAP REL COSTS-BLDG & FIXT				907,570		907,570		21,811		929,381		1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				77,907		77,907		25,538		103,445		2.00	
3.00	00300	OTHER CAP REL COSTS				47,349		47,349		-47,349		0		3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		0		331,884		331,884		0		331,884		4.00	
5.00	00500	ADMINISTRATIVE & GENERAL		317,029		1,398,329		1,715,358		0		1,715,358		5.00	
7.00	00700	OPERATION OF PLANT		0		239,020		239,020		0		239,020		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE		0		36,489		36,489		0		36,489		8.00	
9.00	00900	HOUSEKEEPING		53,970		19,099		73,069		0		73,069		9.00	
10.00	01000	DIETARY		79,112		32,882		111,994		0		111,994		10.00	
11.00	01100	CAFETERIA		0		0		0		0		0		11.00	
13.00	01300	NURSING ADMINISTRATION		206,200		484		206,684		0		206,684		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY		34,231		-12,922		21,309		0		21,309		14.00	
15.00	01500	PHARMACY		141,516		23,919		165,435		0		165,435		15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY		78,003		7,574		85,577		0		85,577		16.00	
17.00	01700	SOCIAL SERVICE		125,096		504		125,600		-41,263		84,337		17.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		0		0		0		0		23.00	
INPATIENT ROUTINE SERVICE COST CENTERS															
30.00	03000	ADULTS & PEDIATRICS		1,027,377		481,612		1,508,989		0		1,508,989		30.00	
31.00	03100	INTENSIVE CARE UNIT		0		0		0		0		0		31.00	
44.00	04400	SKILLED NURSING FACILITY		0		0		0		0		0		44.00	
ANCILLARY SERVICE COST CENTERS															
50.00	05000	OPERATING ROOM		29,415		14,666		44,081		0		44,081		50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		28,718		24,560		53,278		0		53,278		54.00	
60.00	06000	LABORATORY		1,066		81,713		82,779		0		82,779		60.00	
65.00	06500	RESPIRATORY THERAPY		246,347		140,408		386,755		0		386,755		65.00	
66.00	06600	PHYSICAL THERAPY		0		284,253		284,253		0		284,253		66.00	
67.00	06700	OCCUPATIONAL THERAPY		0		0		0		0		0		67.00	
68.00	06800	SPEECH PATHOLOGY		0		0		0		0		0		68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		64,877		64,877		0		64,877		71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0		196,134		196,134		0		196,134		73.00	
74.00	07400	RENAL DIALYSIS		0		96,509		96,509		0		96,509		74.00	
OUTPATIENT SERVICE COST CENTERS															
90.00	09000	CLINIC		0		0		0		0		0		90.00	
91.00	09100	EMERGENCY		0		0		0		0		0		91.00	
OTHER REIMBURSABLE COST CENTERS															
95.00	09500	AMBULANCE SERVICES		0		0		0		0		0		95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0		0		0		0		0		98.00	
SPECIAL PURPOSE COST CENTERS															
118.00		SUBTOTALS (SUM OF LINES 1 through 117)		2,368,080		4,494,820		6,862,900		-41,263		6,821,637		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	NONALLOWABLE CASE MANAGER		0		0		0		6,043		6,043		194.00	
194.01	07951	IDLE SPACE		0		0		0		0		0		194.01	
194.02	07952	DISTRICT		0		0		0		0		0		194.02	
194.03	07953	DISTRICT SALES		0		0		0		0		0		194.03	
194.04	07954	CENTRALIZED ADMISSIONS (CAD)		0		0		0		0		0		194.04	
194.05	07955	CENTRALIZED BUSINESS (CBO)		0		0		0		0		0		194.05	
194.06	07956	CENTRALIZED STAFFING		0		0		0		0		0		194.06	
194.07	07957	HR MANAGED CARE		0		0		0		0		0		194.07	
194.08	07959	LACUNA HEALTH		0		0		0		0		0		194.08	
194.09	07958	SALES & MARKETING		0		0		0		35,220		35,220		194.09	
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS		0		366		366		0		366		194.10	
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION		0		0		0		0		0		194.11	
194.12	07960	VISITOR MEALS		0		0		0		0		0		194.12	
200.00		TOTAL (SUM OF LINES 118 through 199)		2,368,080		4,495,186		6,863,266		0		6,863,266		200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	30,350	959,731	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,487	117,932	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,860	349,744	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-117,152	1,598,206	5.00
7.00	00700	OPERATION OF PLANT	-242	238,778	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,489	8.00
9.00	00900	HOUSEKEEPING	0	73,069	9.00
10.00	01000	DIETARY	-4,097	107,897	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	206,684	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,309	14.00
15.00	01500	PHARMACY	0	165,435	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,095	83,482	16.00
17.00	01700	SOCIAL SERVICE	0	84,337	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	514	1,509,503	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	44,081	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,278	54.00
60.00	06000	LABORATORY	-737	82,042	60.00
65.00	06500	RESPIRATORY THERAPY	0	386,755	65.00
66.00	06600	PHYSICAL THERAPY	-23,012	261,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,877	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	196,134	73.00
74.00	07400	RENAL DIALYSIS	0	96,509	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-84,124	6,737,513	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	NONALLOWABLE CASE MANAGER	0	6,043	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	DISTRICT	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	194.08
194.09	07958	SALES & MARKETING	0	35,220	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	366	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	-84,124	6,779,142	200.00

RECLASSIFICATIONS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-6

Date/Time Prepared:
7/12/2021 5:55 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - RECLASS NON ALLOWABLE CASE MANAGER				
	NONALLOWABLE CASE MANAGER	194.00	6,009	34	1.00
	TOTALS		6,009	34	
1.00	B - RECLASS SALES & MARKETING SALARIES				
	SALES & MARKETING	194.09	35,220		1.00
			35,220	0	
500.00	Grand Total: Increases		41,229	34	500.00

RECLASSIFICATIONS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-6

Date/Time Prepared:
7/12/2021 5:55 pm

	Decreases						7/12/2021 3:00 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL_SERVICE	17.00	6,009	34	0		1.00
	TOTALS		6,009	34			
	B - RECLASS SALES & MARKETING SALARIES						
1.00	SOCIAL_SERVICE	17.00	35,220				1.00
			35,220	0			
500.00	Grand Total: Decreases		41,229	34			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet A-7
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

		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	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	584,452	258,069	0	258,069	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	787,562	213,334	0	213,334	14,470	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	1,372,014	471,403	0	471,403	14,470	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	1,372,014	471,403	0	471,403	14,470	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	842,521	0					
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	986,426	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	1,828,947	0					
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	1,828,947	0					

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet A-7
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	24,735	882,835	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,607	41,300	0	0	0	2.00
3.00	Total (sum of lines 1-2)	61,342	924,135	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	907,570				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	77,907				2.00
3.00	Total (sum of lines 1-2)	0	985,477				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet A-7
Part III
Date/Time Prepared:
7/12/2021 5:55 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	842,521	0	842,521	0.460659	1,768	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	986,425	0	986,425	0.539341	2,071	2.00
3.00	Total (sum of lines 1-2)	1,828,946	0	1,828,946	1.000000	3,839	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	20,043	0	21,811	56,045	882,835	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,467	0	25,538	51,094	41,300	2.00
3.00	Total (sum of lines 1-2)	43,510	0	47,349	107,139	924,135	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	808	20,043	0	959,731	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,071	23,467	0	117,932	2.00
3.00	Total (sum of lines 1-2)	0	2,879	43,510	0	1,077,663	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 5:55 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-96	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,399	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-242	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,051			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-14,396			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-4,097	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,400	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 5:55 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-7,013	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-11,946	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-6,062	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-771	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-18,652	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	A	-10	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	A	-15,617	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-5,151	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.33	EMP BEN - ADMISSION BONUS	A	-6,097	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	87,882	ADMINISTRATIVE & GENERAL	5.00	0	33.34

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 5:55 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	
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-126	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.38
33.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.39
33.40	MISCELLANEOUS EXPENSE	A	-125,951	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.42
33.43	DISTRICT OFFICE SALES AND MARKETING	A	-2,917	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	A	-960	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	24,289	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	-652	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.04
34.05	ASSET ADD-ON BLDG	A	7,370	CAP REL COSTS-BLDG & FIXT	1.00	9	34.05
34.06	ASSET ADD-ON MOV EQUIP	A	16,419	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.06
34.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.07
34.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.08
34.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.09
34.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.10
34.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.11
34.12	NON ALLOWABLE LOBBYING FEES	A	-709	ADMINISTRATIVE & GENERAL	5.00	0	34.12
34.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.13
34.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.14
34.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.17
34.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.18
34.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.19
34.20	PATIENT PHONE - DEPREC BLDG	A	-349	CAP REL COSTS-BLDG & FIXT	1.00	9	34.20
34.21	PATIENT PHONE - DEPREC EQUIP	A	-1,280	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.21
34.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.22
34.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.23
34.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.24
34.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.25

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 5:55 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 #		
34.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.26
34.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.27
34.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.28
34.40	NONALLOWABLE VEBA EXPENSE	A	-118,795	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.40
34.41	ALLOWABLE VEBA CLAIMS	A	136,655	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.41
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
35.01	PHYSICIAN FEE ADJUSTMENT	A	-8,133	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02
35.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.03
35.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.04
35.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.05
35.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.06
35.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.07
35.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	525	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	7,608	ADULTS & PEDIATRICS	30.00	0	35.11
35.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.12
35.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.13
35.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.14
35.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.15
35.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.16
35.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.17
35.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.18
35.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.19
35.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.20
35.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.21
35.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.22
35.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.23
35.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.24
35.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-84,124				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: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8-1

Date/Time Prepared:
7/12/2021 5:55 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	Home Office Costs - Actual	604,333	575,604	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
3.02	0.00			0	0	3.02
3.04	0.00			0	0	3.04
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	83,805	96,242	4.00
4.02	66.00	PHYSICAL THERAPY	Therapy Services	260,028	283,040	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	AfterCare Services	0	696	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Sponsor Fees	585	7,565	4.04
4.27	60.00	LABORATORY	Hospital Related services	19,820	19,820	4.27
5.00	0			968,571	982,967	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	KHOLLC	100.00	6.00
7.00	B		100.00	Cornerstone	100.00	7.00
8.00	B		100.00	RehabCare	100.00	8.00
9.00	B		100.00	Lacuna	100.00	9.00
10.00	B		100.00	TPG/WCAS	76.83	10.00
10.01	B		100.00	KH - Chicago North	100.00	10.01
10.02	B		50.00	KH - ???	100.00	10.02
10.03	B		50.00	KH - ???	100.00	10.03
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: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8-1

Date/Time Prepared:
7/12/2021 5:55 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	28,729	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.02	0	0		3.02
3.04	0	0		3.04
4.00	-12,437	0		4.00
4.02	-23,012	0		4.02
4.03	-696	0		4.03
4.04	-6,980	0		4.04
4.27	0	0		4.27
5.00	-14,396			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 Cost		6.00
7.00	Liability Insur		7.00
8.00	Therapy Svcs		8.00
9.00	AfterCare Svcs		9.00
10.00	Investors		10.00
10.01	Lab Svcs		10.01
10.02	???		10.02
10.03	???		10.03
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: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet A-8-2

Date/Time Prepared:
7/12/2021 5:55 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	187,473	0	187,473	211,500	1,820	1.00
2.00	30.00	DR. B	1,550	0	1,550	211,500	10	2.00
3.00	16.00	DR. C	525	0	525	211,500	3	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	60.00	DR. E	1,488	0	1,488	260,300	6	5.00
6.00	30.00	DR. F	560	0	560	211,500	2	6.00
7.00	30.00	DR. G	3,794	3,794	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			195,390	3,794	191,596		1,841	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	185,063	9,253	0	0	0	1.00
2.00	30.00	DR. B	1,017	51	0	0	0	2.00
3.00	16.00	DR. C	305	15	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	60.00	DR. E	751	38	0	0	0	5.00
6.00	30.00	DR. F	203	10	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			187,339	9,367	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	185,063	2,410	2,410		1.00
2.00	30.00	DR. B	0	1,017	533	533		2.00
3.00	16.00	DR. C	0	305	220	220		3.00
4.00	0.00		0	0	0	0		4.00
5.00	60.00	DR. E	0	751	737	737		5.00
6.00	30.00	DR. F	0	203	357	357		6.00
7.00	30.00	DR. G	0	0	0	3,794		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	187,339	4,257	8,051		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	959,731	959,731			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	117,932		117,932		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	349,744	13,947	1,714	365,405	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,598,206	160,006	19,662	48,919	1,826,793
7.00	00700	OPERATION OF PLANT	238,778	129,215	15,878	0	383,871
8.00	00800	LAUNDRY & LINEN SERVICE	36,489	16,166	1,987	0	54,642
9.00	00900	HOUSEKEEPING	73,069	13,807	1,697	8,328	96,901
10.00	01000	DIETARY	107,897	91,859	11,288	12,207	223,251
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	206,684	8,807	1,082	31,817	248,390
14.00	01400	CENTRAL SERVICES & SUPPLY	21,309	96,251	11,827	5,282	134,669
15.00	01500	PHARMACY	165,435	23,642	2,905	21,836	213,818
16.00	01600	MEDICAL RECORDS & LIBRARY	83,482	13,760	1,691	12,036	110,969
17.00	01700	SOCIAL SERVICE	84,337	7,569	930	12,941	105,777
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,509,503	309,406	38,018	158,531	2,015,458
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,081	0	0	4,539	48,620
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,278	9,789	1,203	4,431	68,701
60.00	06000	LABORATORY	82,042	20,745	2,549	164	105,500
65.00	06500	RESPIRATORY THERAPY	386,755	8,901	1,094	38,012	434,762
66.00	06600	PHYSICAL THERAPY	261,241	35,861	4,407	0	301,509
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,877	0	0	0	64,877
73.00	07300	DRUGS CHARGED TO PATIENTS	196,134	0	0	0	196,134
74.00	07400	RENAL DIALYSIS	96,509	0	0	0	96,509
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,737,513	959,731	117,932	359,043	6,731,151
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	6,043	0	0	927	6,970
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	DISTRICT	0	0	0	0	0
194.03	07953	DISTRICT SALES	0	0	0	0	0
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0
194.07	07957	HR MANAGED CARE	0	0	0	0	0
194.08	07959	LACUNA HEALTH	0	0	0	0	0
194.09	07958	SALES & MARKETING	35,220	0	0	5,435	40,655
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	366	0	0	0	366
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
194.12	07960	VISITOR MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118 through 201)	6,779,142	959,731	117,932	365,405	6,779,142

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,826,793					5.00
7.00	00700	OPERATION OF PLANT	141,600	525,471				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,156	12,939	87,737			8.00
9.00	00900	HOUSEKEEPING	35,744	11,050	0	143,695		9.00
10.00	01000	DIETARY	82,351	73,518	0	21,066	400,186	10.00
11.00	01100	CAFETERIA	0	0	0	0	93,437	11.00
13.00	01300	NURSING ADMINISTRATION	91,625	7,049	0	2,020		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,676	77,033	0	22,073		14.00
15.00	01500	PHARMACY	78,872	18,922	0	5,422		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,934	11,013	0	3,156		16.00
17.00	01700	SOCIAL SERVICE	39,018	6,058	0	1,736		17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	743,450	247,628	87,737	70,954	296,391	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,935	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,342	7,834	0	2,245	0	54.00
60.00	06000	LABORATORY	38,916	16,603	0	4,758	0	60.00
65.00	06500	RESPIRATORY THERAPY	160,372	7,124	0	2,041	0	65.00
66.00	06600	PHYSICAL THERAPY	111,219	28,700	0	8,224	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,931	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,349	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	35,600	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,809,090	525,471	87,737	143,695	389,828	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	NONALLOWABLE CASE MANAGER	2,571	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	14,997	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	135	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	10,358	194.12
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)	1,826,793	525,471	87,737	143,695	400,186	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	93,437					11.00
13.00	01300	NURSING ADMINISTRATION	7,349	356,433				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,100	0	285,551			14.00
15.00	01500	PHARMACY	6,299	0	6,575	329,908		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,150	0	1,515	0	170,737	16.00
17.00	01700	SOCIAL SERVICE	3,150	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,741	350,068	139,399	12,785	83,156	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,050	6,365	0	0	1,133	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,050	0	1,863	0	3,946	54.00
60.00	06000	LABORATORY	0	0	4,206	0	9,412	60.00
65.00	06500	RESPIRATORY THERAPY	11,548	0	54,530	0	29,833	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,348	0	6,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	76,115	0	1,448	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	317,123	32,623	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,468	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,437	356,433	285,551	329,908	170,737	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	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CB0)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	93,437	356,433	285,551	329,908	170,737	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	155,739					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	155,739	0	4,260,506	0	4,260,506	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	75,103	0	75,103	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	110,981	0	110,981	54.00
60.00	06000	LABORATORY	0	0	179,395	0	179,395	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	700,210	0	700,210	65.00
66.00	06600	PHYSICAL THERAPY	0	0	457,718	0	457,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	166,371	0	166,371	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	618,229	0	618,229	73.00
74.00	07400	RENAL DIALYSIS	0	0	134,577	0	134,577	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,739	0	6,703,090	0	6,703,090	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	NONALLOWABLE CASE MANAGER	0	0	9,541	0	9,541	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CB0)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	55,652	0	55,652	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	501	0	501	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	10,358	0	10,358	194.12
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)	155,739	0	6,779,142	0	6,779,142	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
			Directly Assigned New Capital Related Costs	BLDG & FIXT				MVBLE EQUIP
			0	1.00				2.00
	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	13,947	1,714	15,661	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	57,040	160,006	19,662	236,708	5.00	
7.00	00700	OPERATION OF PLANT	0	129,215	15,878	145,093	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,166	1,987	18,153	8.00	
9.00	00900	HOUSEKEEPING	0	13,807	1,697	15,504	9.00	
10.00	01000	DIETARY	0	91,859	11,288	103,147	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	8,807	1,082	9,889	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	96,251	11,827	108,078	14.00	
15.00	01500	PHARMACY	0	23,642	2,905	26,547	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,760	1,691	15,451	16.00	
17.00	01700	SOCIAL SERVICE	0	7,569	930	8,499	17.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	309,406	38,018	347,424	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	195	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,789	1,203	10,992	54.00	
60.00	06000	LABORATORY	0	20,745	2,549	23,294	60.00	
65.00	06500	RESPIRATORY THERAPY	0	8,901	1,094	9,995	65.00	
66.00	06600	PHYSICAL THERAPY	0	35,861	4,407	40,268	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00	
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,040	959,731	117,932	1,134,703	118.00	
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00	
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	40	194.00	
194.01	07951	IDLE SPACE	0	0	0	0	194.01	
194.02	07952	DISTRICT	0	0	0	0	194.02	
194.03	07953	DISTRICT SALES	0	0	0	0	194.03	
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	194.04	
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	194.05	
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	194.06	
194.07	07957	HR MANAGED CARE	0	0	0	0	194.07	
194.08	07959	LACUNA HEALTH	0	0	0	0	194.08	
194.09	07958	SALES & MARKETING	0	0	0	233	194.09	
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10	
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11	
194.12	07960	VISITOR MEALS	0	0	0	0	194.12	
200.00		Cross Foot Adjustments				0	200.00	
201.00		Negative Cost Centers		0	0	0	201.00	
202.00		TOTAL (sum lines 118 through 201)	57,040	959,731	117,932	1,134,703	202.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part II
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7/12/2021 5:55 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	238,805					5.00
7.00	00700	OPERATION OF PLANT	18,511	163,604				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,635	4,028	24,816			8.00
9.00	00900	HOUSEKEEPING	4,673	3,440	0	23,974		9.00
10.00	01000	DIETARY	10,765	22,890	0	3,515	140,840	10.00
11.00	01100	CAFETERIA	0	0	0	0	32,884	11.00
13.00	01300	NURSING ADMINISTRATION	11,978	2,195	0	337	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,494	23,984	0	3,683	0	14.00
15.00	01500	PHARMACY	10,311	5,891	0	905	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,351	3,429	0	526	0	16.00
17.00	01700	SOCIAL SERVICE	5,101	1,886	0	290	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	97,183	77,099	24,816	11,836	104,311	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,345	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,313	2,439	0	375	0	54.00
60.00	06000	LABORATORY	5,087	5,169	0	794	0	60.00
65.00	06500	RESPIRATORY THERAPY	20,965	2,218	0	341	0	65.00
66.00	06600	PHYSICAL THERAPY	14,539	8,936	0	1,372	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,128	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,458	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,654	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	236,491	163,604	24,816	23,974	137,195	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	NONALLOWABLE CASE MANAGER	336	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	1,960	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	18	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	3,645	194.12
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)	238,805	163,604	24,816	23,974	140,840	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	32,884					11.00
13.00	01300	NURSING ADMINISTRATION	2,586	28,349				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	739	0	143,204			14.00
15.00	01500	PHARMACY	2,217	0	3,297	50,104		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,108	0	760	0	27,141	16.00
17.00	01700	SOCIAL SERVICE	1,108	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,324	27,843	69,909	1,942	13,220	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	369	506	0	0	180	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	369	0	934	0	627	54.00
60.00	06000	LABORATORY	0	0	2,109	0	1,496	60.00
65.00	06500	RESPIRATORY THERAPY	4,064	0	27,347	0	4,742	65.00
66.00	06600	PHYSICAL THERAPY	0	0	676	0	1,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	38,172	0	230	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	48,162	5,186	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	392	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,884	28,349	143,204	50,104	27,141	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	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CB0)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	32,884	28,349	143,204	50,104	27,141	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet B
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	17,439					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,439		820,139	0	820,139	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		3,595	0	3,595	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		19,239	0	19,239	54.00
60.00	06000	LABORATORY	0		37,956	0	37,956	60.00
65.00	06500	RESPIRATORY THERAPY	0		71,301	0	71,301	65.00
66.00	06600	PHYSICAL THERAPY	0		66,859	0	66,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		41,530	0	41,530	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		62,806	0	62,806	73.00
74.00	07400	RENAL DIALYSIS	0		5,046	0	5,046	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,439	0	1,128,471	0	1,128,471	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0		376	0	376	194.00
194.01	07951	IDLE SPACE	0		0	0	0	194.01
194.02	07952	DISTRICT	0		0	0	0	194.02
194.03	07953	DISTRICT SALES	0		0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0		0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CB0)	0		0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0		0	0	0	194.06
194.07	07957	HR MANAGED CARE	0		0	0	0	194.07
194.08	07959	LACUNA HEALTH	0		0	0	0	194.08
194.09	07958	SALES & MARKETING	0		2,193	0	2,193	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0		18	0	18	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0		0	0	0	194.11
194.12	07960	VISITOR MEALS	0		3,645	0	3,645	194.12
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,439	0	1,134,703	0	1,134,703	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	41,081				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		41,081			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	597	597	2,368,080		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,849	6,849	317,029	-1,826,793	5.00
7.00	00700	OPERATION OF PLANT	5,531	5,531	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	692	692	0	0	8.00
9.00	00900	HOUSEKEEPING	591	591	53,970	0	9.00
10.00	01000	DIETARY	3,932	3,932	79,112	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	377	377	206,200	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,120	4,120	34,231	0	14.00
15.00	01500	PHARMACY	1,012	1,012	141,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589	589	78,003	0	16.00
17.00	01700	SOCIAL SERVICE	324	324	83,867	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,244	13,244	1,027,377	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	29,415	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419	419	28,718	0	54.00
60.00	06000	LABORATORY	888	888	1,066	0	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	246,347	0	65.00
66.00	06600	PHYSICAL THERAPY	1,535	1,535	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,081	41,081	2,326,851	-1,826,793	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	6,009	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	35,220	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	194.12
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)	959,731	117,932	365,405	1,826,793	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.361919	2.870719	0.154304	0.368874	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,661	238,805	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.006613	0.048221	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: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	28,104				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	692	3,361			8.00
9.00	00900	HOUSEKEEPING	591	0	26,821		9.00
10.00	01000	DIETARY	3,932	0	3,932	5,525	10.00
11.00	01100	CAFETERIA	0	0	0	1,290	89 11.00
13.00	01300	NURSING ADMINISTRATION	377	0	377	0	7 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,120	0	4,120	0	2 14.00
15.00	01500	PHARMACY	1,012	0	1,012	0	6 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589	0	589	0	3 16.00
17.00	01700	SOCIAL SERVICE	324	0	324	0	3 17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,244	3,361	13,244	4,092	55 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	1 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419	0	419	0	1 54.00
60.00	06000	LABORATORY	888	0	888	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	381	0	381	0	11 65.00
66.00	06600	PHYSICAL THERAPY	1,535	0	1,535	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,104	3,361	26,821	5,382	89 118.00
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	NONALLOWABLE CASE MANAGER	0	0	0	0	0 194.00
194.01	07951	IDLE SPACE	0	0	0	0	0 194.01
194.02	07952	DISTRICT	0	0	0	0	0 194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0 194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0 194.04
194.05	07955	CENTRALIZED BUSINESS (CB0)	0	0	0	0	0 194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0 194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0 194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0 194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0 194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
194.12	07960	VISITOR MEALS	0	0	0	143	0 194.12
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)	525,471	87,737	143,695	400,186	93,437 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.697374	26.104433	5.357556	72.431855	1,049.853933 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	163,604	24,816	23,974	140,840	32,884 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.821378	7.383517	0.893852	25.491403	369.483146 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: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			NURSING ADMINISTRATIO N (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	56					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	243,391				14.00
15.00	01500	PHARMACY	0	5,604	204,041			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,291	0	22,924,912		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	3,361	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	55	118,818	7,907	11,165,858	3,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1	0	0	152,062	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,588	0	529,850	0	54.00
60.00	06000	LABORATORY	0	3,585	0	1,263,747	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,479	0	4,005,442	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,149	0	901,979	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,877	0	194,414	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	196,134	4,380,129	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	331,431	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56	243,391	204,041	22,924,912	3,361	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	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	356,433	285,551	329,908	170,737	155,739	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6,364.875000	1.173219	1.616871	0.007448	46.337102	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,349	143,204	50,104	27,141	17,439	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	506.232143	0.588370	0.245558	0.001184	5.188634	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: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		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
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	194.00
194.01	07951	IDLE SPACE	194.01
194.02	07952	DISTRICT	194.02
194.03	07953	DISTRICT SALES	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	194.05
194.06	07956	CENTRALIZED STAFFING	194.06
194.07	07957	HR MANAGED CARE	194.07
194.08	07959	LACUNA HEALTH	194.08
194.09	07958	SALES & MARKETING	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	194.11
194.12	07960	VISITOR MEALS	194.12
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,260,506		4,260,506	3,300	4,263,806	30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	75,103		75,103	0	75,103	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,981		110,981	0	110,981	54.00	
60.00	06000	LABORATORY	179,395		179,395	737	180,132	60.00	
65.00	06500	RESPIRATORY THERAPY	700,210	0	700,210	0	700,210	65.00	
66.00	06600	PHYSICAL THERAPY	457,718	0	457,718	0	457,718	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	166,371		166,371	0	166,371	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	618,229		618,229	0	618,229	73.00	
74.00	07400	RENAL DIALYSIS	134,577		134,577	0	134,577	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	0		0	0	0	91.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00	
200.00		Subtotal (see instructions)	6,703,090	0	6,703,090	4,037	6,707,127	200.00	
201.00		Less Observation Beds	0		0	0	0	201.00	
202.00		Total (see instructions)	6,703,090	0	6,703,090	4,037	6,707,127	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

			Title XVIII		Hospital		7/12/2021 3:33 pm PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,165,858		11,165,858			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	152,062	0	152,062	0.493897	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,639	211	529,850	0.209457	0.000000	54.00
60.00	06000	LABORATORY	1,262,746	1,001	1,263,747	0.141955	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,004,981	461	4,005,442	0.174815	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	901,979	0	901,979	0.507460	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	194,414	0	194,414	0.855756	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,380,129	0	4,380,129	0.141144	0.000000	73.00
74.00	07400	RENAL DIALYSIS	331,431	0	331,431	0.406048	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	22,923,239	1,673	22,924,912			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,923,239	1,673	22,924,912			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.493897		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209457		54.00
60.00	06000	LABORATORY	0.142538		60.00
65.00	06500	RESPIRATORY THERAPY	0.174815		65.00
66.00	06600	PHYSICAL THERAPY	0.507460		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.855756		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141144		73.00
74.00	07400	RENAL DIALYSIS	0.406048		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
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: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,260,506		4,260,506	3,300	4,263,806	30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	75,103		75,103	0	75,103	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,981		110,981	0	110,981	54.00	
60.00	06000	LABORATORY	179,395		179,395	737	180,132	60.00	
65.00	06500	RESPIRATORY THERAPY	700,210	0	700,210	0	700,210	65.00	
66.00	06600	PHYSICAL THERAPY	457,718	0	457,718	0	457,718	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	166,371		166,371	0	166,371	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	618,229		618,229	0	618,229	73.00	
74.00	07400	RENAL DIALYSIS	134,577		134,577	0	134,577	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	0		0	0	0	91.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00	
200.00		Subtotal (see instructions)	6,703,090	0	6,703,090	4,037	6,707,127	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	6,703,090	0	6,703,090	4,037	6,707,127	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 5:55 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	11,165,858		11,165,858			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	152,062	0	152,062	0.493897	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,639	211	529,850	0.209457	0.000000	54.00
60.00	06000	LABORATORY	1,262,746	1,001	1,263,747	0.141955	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,004,981	461	4,005,442	0.174815	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	901,979	0	901,979	0.507460	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	194,414	0	194,414	0.855756	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,380,129	0	4,380,129	0.141144	0.000000	73.00
74.00	07400	RENAL DIALYSIS	331,431	0	331,431	0.406048	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	22,923,239	1,673	22,924,912			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,923,239	1,673	22,924,912			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 5:55 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
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet D
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		820,139	0	820,139	3,361	244.02	30.00
31.00	INTENSIVE CARE UNIT		0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY		0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)		820,139		820,139	3,361		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,094	266,958				
31.00	INTENSIVE CARE UNIT		0	0				
44.00	SKILLED NURSING FACILITY		0	0				
200.00	Total (lines 30 through 199)		1,094	266,958				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet D
Part II
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,595	152,062	0.023642	41,064	971
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,239	529,850	0.036310	194,176	7,051
60.00	06000	LABORATORY	37,956	1,263,747	0.030034	492,747	14,799
65.00	06500	RESPIRATORY THERAPY	71,301	4,005,442	0.017801	1,479,992	26,345
66.00	06600	PHYSICAL THERAPY	66,859	901,979	0.074125	253,518	18,792
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,530	194,414	0.213616	67,828	14,489
73.00	07300	DRUGS CHARGED TO PATIENTS	62,806	4,380,129	0.014339	1,654,769	23,728
74.00	07400	RENAL DIALYSIS	5,046	331,431	0.015225	212,941	3,242
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	0	0	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	308,332	11,759,054		4,397,035	109,417

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet D Part III Date/Time Prepared: 7/12/2021 5:55 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	3,361	0.00	1,094	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	3,361		1,094	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet D
Part IV
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet D Part IV Date/Time Prepared: 7/12/2021 5:55 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	152,062	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	529,850	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,263,747	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,005,442	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	901,979	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	194,414	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,380,129	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	331,431	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	11,759,054		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-2006		Period: From 09/01/2020 To 12/15/2020		Worksheet D Part IV Date/Time Prepared: 7/12/2021 5:55 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	41,064	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	194,176	0	0	0	54.00
60.00	06000	LABORATORY		0.000000	492,747	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,479,992	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	253,518	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	67,828	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,654,769	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	212,941	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)			4,397,035	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet D-1 Date/Time Prepared: 7/12/2021 5:55 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,361	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,361	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)			3,361	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,094	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,263,806	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,263,806	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,263,806	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,268.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,387,859	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)			1,387,859	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					896,632	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,284,491	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					266,958	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					109,417	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					376,375	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,908,116	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 5:55 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	820,139	4,263,806	0.192349	0	0	90.00
91.00 Nursing School cost	0	4,263,806	0.000000	0	0	91.00
92.00 Allied health cost	0	4,263,806	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,263,806	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet D-1 Date/Time Prepared: 7/12/2021 5:55 pm
		Title XIX	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)		3,361	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,361	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)		3,361	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		263	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,260,506	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,260,506	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,260,506	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,267.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		333,387	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)		333,387	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					174,067	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					507,454	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 5:55 pm

		Title XIX		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	820,139	4,260,506	0.192498	0	0
91.00	Nursing School cost	0	4,260,506	0.000000	0	0
92.00	Allied health cost	0	4,260,506	0.000000	0	0
93.00	All other Medical Education	0	4,260,506	0.000000	0	0

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-2

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00 Total cost of services rendered	0.00	0				1.00
Hospital Inpatient Routine Services:						
2.00 ADULTS & PEDIATRICS	0.00	0	3,361	0.00	0	2.00
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00
4.00 CORONARY CARE UNIT						4.00
5.00 BURN INTENSIVE CARE UNIT						5.00
6.00 SURGICAL INTENSIVE CARE UNIT						6.00
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00
8.00 NURSERY						8.00
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00
10.00 SUBPROVIDER - IPF						10.00
11.00 SUBPROVIDER - IRF						11.00
12.00 SUBPROVIDER						12.00
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00
14.00 NURSING FACILITY						14.00
15.00 OTHER LONG TERM CARE						15.00
16.00 HOME HEALTH AGENCY						16.00
17.00 CMHC						17.00
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00 HOSPICE						19.00
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00
Cost Center Description Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93) Ratio of Cost to Charges (col. 2 ÷ col. 3) Titles V and XIX Outpatient and Title XVIII Part B Charges Title V						
	1.00	2.00	3.00	4.00	5.00	
Hospital Outpatient Services:						
21.00 RURAL HEALTH CLINIC						21.00
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00 CLINIC	0.00	0	0	0.000000	0	23.00
24.00 EMERGENCY	0.00	0	0	0.000000	0	24.00
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00
Cost Center Description Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 Swing bed Amount Net cost (column 1 plus column 2) Total Inpatient Days - All Patients Average Cost Per Day (col. 3 ÷ col. 4)						
	1.00	2.00	3.00	4.00	5.00	
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00 ADULTS & PEDIATRICS	0	0	0	3,361	0.00	29.00
30.00 Swing Bed - SNF		0	0	0	0.00	30.00
31.00 Swing Bed - NF		0				31.00
32.00 INTENSIVE CARE UNIT	0		0	0	0.00	32.00
33.00 CORONARY CARE UNIT						33.00
34.00 BURN INTENSIVE CARE UNIT						34.00
35.00 SURGICAL INTENSIVE CARE UNIT						35.00
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00
37.00 Subtotal (sum of lines 29, and 32 through 36)	0		0			37.00
38.00 SUBPROVIDER - IPF						38.00
39.00 SUBPROVIDER - IRF						39.00
40.00 SUBPROVIDER						40.00
41.00 SKILLED NURSING FACILITY	0		0	0	0.00	41.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-2

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	Total (sum of lines 37 through 41)	0		0			42.00
Cost Center Description		Not In Approved Teaching Program			In Approved Teaching Program		
		(from Part I:)		Amount	(from Part II, col. 7, -)		
		1.00		2.00	3.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)							
Hospital							
43.00	Inpatient	col. 9, line 9.00		0	line 37.00		
44.00	Outpatient	col. 9, line 27.00		0			
45.00	Total Hospital (sum of lines 43 and 44)			0			
46.00	SUBPROVIDER - IPF						
47.00	SUBPROVIDER - IRF						
48.00	SUBPROVIDER						
49.00	SKILLED NURSING FACILITY	col. 9, line 13.00		0	col. 9, line 41.00		

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-2

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX				
		6.00	7.00		8.00	9.00	
PART I - NOT IN APPROVED TEACHING PROGRAM							
1.00	Total cost of services rendered						1.00
Hospital Inpatient Routine Services:							
2.00	ADULTS & PEDIATRICS	1,094	263	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
Hospital Outpatient Services:							
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			
		6.00	7.00	11.00			
		PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)					
Hospital Inpatient Routine Services:							
29.00	ADULTS & PEDIATRICS	0	0	0			29.00
30.00	Swing Bed - SNF	0	0				30.00
31.00	Swing Bed - NF						31.00
32.00	INTENSIVE CARE UNIT	0	0	0			32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0	0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0	0	0			41.00
42.00	Total (sum of lines 37 through 41)		0	0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet D-2

Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00 Inpatient	0		0		43.00
44.00 Outpatient					44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46.00 SUBPROVIDER - IPF					46.00
47.00 SUBPROVIDER - IRF					47.00
48.00 SUBPROVIDER					48.00
49.00 SKILLED NURSING FACILITY	0	line 22	0		49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet D-3 Date/Time Prepared: 7/12/2021 5:55 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,635,002		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.493897	41,064	20,281	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209457	194,176	40,672	54.00
60.00	06000	LABORATORY	0.142538	492,747	70,235	60.00
65.00	06500	RESPIRATORY THERAPY	0.174815	1,479,992	258,725	65.00
66.00	06600	PHYSICAL THERAPY	0.507460	253,518	128,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.855756	67,828	58,044	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141144	1,654,769	233,561	73.00
74.00	07400	RENAL DIALYSIS	0.406048	212,941	86,464	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,397,035	896,632	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)		4,397,035		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet D-3 Date/Time Prepared: 7/12/2021 5:55 pm
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		866,801	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.493897	13,500	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209457	28,032	54.00
60.00	06000	LABORATORY	0.141955	109,998	60.00
65.00	06500	RESPIRATORY THERAPY	0.174815	275,004	65.00
66.00	06600	PHYSICAL THERAPY	0.507460	75,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.855756	12,996	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141144	296,008	73.00
74.00	07400	RENAL DIALYSIS	0.406048	16,623	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		827,412	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)		827,412	202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet E-1
Part I
Date/Time Prepared:
7/12/2021 5:55 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,108,396		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	12/01/2020	44,200		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		44,200		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,152,596		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		132,094		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,284,690		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet E-3 Part IV Date/Time Prepared: 7/12/2021 5:55 pm
		Title XVIII	Hospital	PPS
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		2,330,026	1.00
1.01	Full standard payment amount		1,725,785	1.01
1.02	Short stay outlier standard payment amount		604,241	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		0	1.04
2.00	Outlier Payments		88,753	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		2,418,779	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		2,418,779	7.00
8.00	Primary payer payments		19,548	8.00
9.00	Subtotal (line 7 less line 8).		2,399,231	9.00
10.00	Deductibles		5,632	10.00
11.00	Subtotal (line 9 minus line 10)		2,393,599	11.00
12.00	Coinsurance		115,456	12.00
13.00	Subtotal (line 11 minus line 12)		2,278,143	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		10,072	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		6,547	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,072	16.00
17.00	Subtotal (sum of lines 13 and 15)		2,284,690	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		2,284,690	22.00
22.01	Sequestration adjustment (see instructions)		0	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		2,152,596	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		132,094	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		88,753	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2006	Period: From 09/01/2020 To 12/15/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/12/2021 5:55 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		507,454		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		507,454	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		507,454	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		866,801		8.00
9.00	Ancillary service charges		827,412	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,694,213	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,694,213	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,186,759	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		507,454	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		507,454	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		507,454	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		507,454	0	36.00
37.00	OTHER ADJUSTMENTS		0		37.00
37.01	OTHER ADJUSTMENTS		0		37.01
38.00	Subtotal (line 36 ± line 37)		507,454	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		507,454	0	40.00
41.00	Interim payments		385,811		41.00
42.00	Balance due provider/program (line 40 minus line 41)		121,643		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

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

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet G

Date/Time Prepared:
7/12/2021 5:55 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	6,612	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	6,884,257	0	0	0	4.00
5.00	Other receivable	173	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,453,537	0	0	0	6.00
7.00	Inventory	423,617	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,861,122	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	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	362,151	0	0	0	15.00
16.00	Accumulated depreciation	-362,151	0	0	0	16.00
17.00	Leasehold improvements	863,723	0	0	0	17.00
18.00	Accumulated depreciation	-284,377	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	1,295,595	0	0	0	23.00
24.00	Accumulated depreciation	-398,942	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)	1,475,999	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	17,274,658	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,274,658	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,611,779	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,509,971	0	0	0	37.00
38.00	Salaries, wages, and fees payable	617,033	0	0	0	38.00
39.00	Payroll taxes payable	6,815	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	31,483,230	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	33,617,049	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	-1,040,917	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-1,040,917	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,576,132	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-7,964,353	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)	-7,964,353	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,611,779	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet G-1

Date/Time Prepared:
7/12/2021 5:55 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		-5,858,489		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		576,375				2.00
3.00	Total (sum of line 1 and line 2)		-5,282,114		0		3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	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)		-5,282,114		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	2,682,239		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)		2,682,239		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,964,353		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)		0				4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)		0				12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		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: 14-2006

Period:
From 09/01/2020
To 12/15/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/12/2021 5:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,165,858		11,165,858	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,165,858		11,165,858	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,165,858		11,165,858	17.00
18.00	Ancillary services	11,757,381	1,673	11,759,054	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,923,239	1,673	22,924,912	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		6,863,266		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		6,863,266		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2020
To 12/15/2020

Worksheet G-3

Date/Time Prepared:
7/12/2021 5:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	22,924,912	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,493,983	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,430,929	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	6,863,266	4.00
5.00	Net income from service to patients (line 3 minus line 4)	567,663	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	96	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	4,097	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	2,400	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	MISCELLANEOUS INCOME	2,119	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,712	25.00
26.00	Total (line 5 plus line 25)	576,375	26.00
27.00	OTHER EXPENSES	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)	576,375	29.00