

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: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet S Parts I-III Date/Time Prepared: 1/27/2022 8:10 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/27/2022	Time: 8:10 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Chicago (14-2008) for the cost reporting period beginning 12/16/2020 and ending 08/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	143,746	24,721	0	2,487,363	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	143,746	24,721	0	2,487,363	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: 14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 8:10 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 365 East North Avenue			PO Box:				1.00	
2.00	City: Northlake			State: IL		Zip Code: 60164		County: COOK 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			Kindred Hospital Chicago	142008	16984	2	04/01/1991	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)						12/16/2020	08/31/2021	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
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 8:10 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr			
					1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1						26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:			
					1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
					Y/N	Y/N			
					1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N					N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N					N	40.00	
					V	XVIII	XIX		
					1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 8:10 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-2
Part I
Date/Time Prepared:
1/27/2022 8:10 am

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 8:10 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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	3.00			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				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:	259,944	0	631,946		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 8:10 am	
		1.00	2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	Removed and reserved			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
					1.00
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00	
		Name	County	State	Zip Code
		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
166.01					0.00
166.02					0.00
166.03					0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/27/2022 8:10 am
			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
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N 0 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet S-2 Part II Date/Time Prepared: 1/27/2022 8:10 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			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	03/31/2022	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 a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	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	11/30/2021	Y	11/30/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/27/2022 8:10 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	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.		Y	12/31/2021	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/27/2022 8:10 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/27/2022 8:10 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	185	47,915	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)		185	47,915	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)		185	47,915	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)		185				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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/27/2022 8:10 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,383	2,903	29,463		1.00
2.00	HMO and other (see instructions)	3,996	11,126			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)	7,383	2,903	29,463		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)	7,383	2,903	29,463	0.00	339.00
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				27.00
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	41				32.00
33.01	LTCH site neutral days and discharges	0				32.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/27/2022 8:10 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	301	93	1,309	1.00
2.00 HMO and other (see instructions)			144	578		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	301	93	1,309	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part II
Date/Time Prepared:
1/27/2022 8:10 am

	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	18,995,866	0	18,995,866	529,197.11	35.90 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	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		0	281,864	281,864	4,357.89	64.68 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		8,092,928	0	8,092,928	87,028.00	92.99 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		607,449	0	607,449	5,856.00	103.73 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		5,412,861	0	5,412,861	71,745.34	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)		2,829,456	0	2,829,456		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		43,249	0	43,249		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part II
Date/Time Prepared:
1/27/2022 8:10 am

		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	1,719,867	0	1,719,867	35,069.00	49.04	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	606,606	0	606,606	36,048.00	16.83	32.00
33.00	Housekeeping under contract (see instructions)		227,172	0	227,172	8,517.00	26.67	33.00
34.00	Dietary	10.00	601,067	0	601,067	31,256.00	19.23	34.00
35.00	Dietary under contract (see instructions)		18,776	0	18,776	689.00	27.25	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	1,032,293	0	1,032,293	23,307.00	44.29	38.00
39.00	Central Services and Supply	14.00	154,091	0	154,091	8,531.00	18.06	39.00
40.00	Pharmacy	15.00	1,000,572	0	1,000,572	22,163.00	45.15	40.00
41.00	Medical Records & Medical Records Library	16.00	688,290	0	688,290	22,059.00	31.20	41.00
42.00	Social Service	17.00	1,091,766	-281,864	809,902	18,231.11	44.42	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part III
Date/Time Prepared:
1/27/2022 8:10 am

	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)	19,241,814	0	19,241,814	538,403.11	35.74	1.00
2.00	Excluded area salaries (see instructions)	0	281,864	281,864	4,357.89	64.68	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,241,814	-281,864	18,959,950	534,045.22	35.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,113,238	0	14,113,238	164,629.34	85.73	4.00
5.00	Subtotal wage-related costs (see inst.)	2,829,456	0	2,829,456	0.00	14.92	5.00
6.00	Total (sum of lines 3 thru 5)	36,184,508	-281,864	35,902,644	698,674.56	51.39	6.00
7.00	Total overhead cost (see instructions)	7,140,500	-281,864	6,858,636	205,870.11	33.32	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
1/27/2022 8:10 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	33,220	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)	966,798	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	-9,659	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,589	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)	74,116	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	217,457	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	1,353,995	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	174,197	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	9,744	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,829,457	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet S-3
Part V
Date/Time Prepared:
1/27/2022 8:10 am

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	8,092,928	2,829,456	1.00
2.00	Hospital	8,092,928	2,829,456	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,085,537	4,085,537	823,797	4,909,334	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		807,801	807,801	444,623	1,252,424	2.00
3.00	00300	OTHER CAP REL COSTS		1,268,420	1,268,420	-1,268,420	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,025,812	3,025,812	0	3,025,812	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,719,867	16,730,180	18,450,047	0	18,450,047	5.00
7.00	00700	OPERATION OF PLANT	0	3,020,524	3,020,524	-22,603	2,997,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	219,173	219,173	0	219,173	8.00
9.00	00900	HOUSEKEEPING	606,606	461,053	1,067,659	0	1,067,659	9.00
10.00	01000	DIETARY	601,067	450,318	1,051,385	0	1,051,385	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,032,293	12,300	1,044,593	0	1,044,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	154,091	-84,616	69,475	0	69,475	14.00
15.00	01500	PHARMACY	1,000,572	59,872	1,060,444	0	1,060,444	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	688,290	87,138	775,428	0	775,428	16.00
17.00	01700	SOCIAL SERVICE	1,091,766	28,693	1,120,459	-284,523	835,936	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	8,390,056	9,133,354	17,523,410	0	17,523,410	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	459,488	438,259	897,747	0	897,747	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	200,299	107,773	308,072	22,603	330,675	54.00
60.00	06000	LABORATORY	519,180	767,756	1,286,936	0	1,286,936	60.00
65.00	06500	RESPIRATORY THERAPY	1,986,462	1,213,934	3,200,396	0	3,200,396	65.00
66.00	06600	PHYSICAL THERAPY	1,165	1,306,522	1,307,687	0	1,307,687	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	544,266	544,266	0	544,266	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,614,122	1,614,122	0	1,614,122	73.00
74.00	07400	RENAL DIALYSIS	544,664	806,558	1,351,222	0	1,351,222	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)	18,995,866	46,104,749	65,100,615	-284,523	64,816,092	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	64,410	64,410	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	220,113	220,113	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	260,957	260,957	0	260,957	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)	18,995,866	46,365,706	65,361,572	0	65,361,572	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	267,454	5,176,788	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	45,155	1,297,579	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	268,732	3,294,544	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,169,283	15,280,764	5.00
7.00	00700	OPERATION OF PLANT	-2,230	2,995,691	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	219,173	8.00
9.00	00900	HOUSEKEEPING	0	1,067,659	9.00
10.00	01000	DIETARY	-9,484	1,041,901	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,044,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	69,475	14.00
15.00	01500	PHARMACY	0	1,060,444	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,322	777,750	16.00
17.00	01700	SOCIAL SERVICE	0	835,936	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,587,290	15,936,120	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	-243,501	654,246	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,480	339,155	54.00
60.00	06000	LABORATORY	-2,495	1,284,441	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,200,396	65.00
66.00	06600	PHYSICAL THERAPY	-104,770	1,202,917	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	544,266	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,614,122	73.00
74.00	07400	RENAL DIALYSIS	0	1,351,222	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)	-4,526,910	60,289,182	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	64,410	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	220,113	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	260,957	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)	-4,526,910	60,834,662	200.00

RECLASSIFICATIONS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-6

Date/Time Prepared:
1/27/2022 8:10 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RECLASS NON ALLOWABLE CASE MANAGER					1.00
	NONALLOWABLE CASE MANAGER	194.00	61,751	2,659		
	TOTALS		61,751	2,659		
1.00	B - RECLASS SALES & MARKETING SALARIES					1.00
	SALES & MARKETING	194.09	220,113			
			220,113	0		
1.00	C - PHILLIPS IMAGING					1.00
	RADIOLOGY-DIAGNOSTIC	54.00		22,603		
			0	22,603		
500.00	Grand Total: Increases		281,864	25,262		500.00

RECLASSIFICATIONS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-6

Date/Time Prepared:
1/27/2022 8:10 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RECLASS NON ALLOWABLE CASE MANAGER						1.00
	SOCIAL SERVICE	17.00	61,751	2,659	0		
	TOTALS		61,751	2,659			
1.00	B - RECLASS SALES & MARKETING SALARIES						1.00
	SOCIAL SERVICE	17.00	220,113				
			220,113	0			
1.00	C - PHILLIPS IMAGING						1.00
	OPERATION OF PLANT	7.00		22,603			
			0	22,603			
500.00	Grand Total: Decreases		281,864	25,262			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet A-7
Part I
Date/Time Prepared:
1/27/2022 8:10 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,170,000	0	0	0	0	1.00
2.00	Land Improvements	17,000	0	0	0	0	2.00
3.00	Buildings and Fixtures	427,191	0	0	0	0	3.00
4.00	Building Improvements	4,589,988	431,319	0	431,319	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	3,621,267	1,053,275	0	1,053,275	13,763	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,825,446	1,484,594	0	1,484,594	13,763	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,825,446	1,484,594	0	1,484,594	13,763	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,170,000	0				1.00
2.00	Land Improvements	17,000	0				2.00
3.00	Buildings and Fixtures	427,191	0				3.00
4.00	Building Improvements	5,021,307	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,660,779	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	13,296,277	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	13,296,277	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet A-7
Part II
Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	599,122	3,486,415	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	414,383	393,418	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,013,505	3,879,833	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	4,085,537				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	807,801				2.00
3.00	Total (sum of lines 1-2)	0	4,893,338				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet A-7
Part III
Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,635,499	0	8,635,499	0.649467	62,090	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,660,779	0	4,660,779	0.350533	33,511	2.00
3.00	Total (sum of lines 1-2)	13,296,278	0	13,296,278	1.000000	95,601	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	761,707	0	823,797	890,476	3,486,415	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	411,112	0	444,623	459,538	393,418	2.00
3.00	Total (sum of lines 1-2)	1,172,819	0	1,268,420	1,350,014	3,879,833	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	38,190	761,707	0	5,176,788	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	33,511	411,112	0	1,297,579	2.00
3.00	Total (sum of lines 1-2)	0	71,701	1,172,819	0	6,474,367	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		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	-437	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	-11,185	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,230	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	-1,854,658			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	-1,214,176			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-9,484	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	2,322	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-262,565	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	PATIENT PERSONAL SERVICES EXPENSE	A	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	A	-5,506	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-1,020,195	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	-95,023	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-2,155	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	A	-1,031	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-203,295	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	A	-261	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER OPERATING - CASH OVER SHORT	A	1	ADMINISTRATIVE & GENERAL	5.00	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 OPERATING - TRADE SHOW BOOTH	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	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	CHARITABLE CONTRIBUTIONS	A	-5,484	ADMINISTRATIVE & GENERAL	5.00	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	-126,370	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-68,249	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	-36,134	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	358,925	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-40,072	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	-470,096	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	-17,840	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	-23,900	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	291,354	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	62,017	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	0	CAP REL COSTS-BLDG & FIXT	1.00	9	34.05
34.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	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	-20,002	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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.20
34.21	PATIENT PHONE - DEPREC EQUIP	A	-16,862	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
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	-976,095	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.40
34.41	ALLOWABLE VEBA CLAIMS	A	1,244,827	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	-29,853	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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.09
35.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	39,912	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	PHYSICIAN FEE ADJUSTMENT	A	-18,540	OPERATING ROOM	50.00	0	35.16
35.17	PHYSICIAN FEE ADJUSTMENT	A	8,480	RADIOLOGY-DIAGNOSTIC	54.00	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.)		-4,526,910				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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/27/2022 8:10 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs - Actual	350,567	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs - Estimate	5,682,780	6,510,404	2.00
3.00	0.00			0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	182,513	749,330	4.00
4.02	66.00	PHYSICAL THERAPY	Therapy Services	1,183,843	1,288,613	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	AfterCare Services	0	16,363	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Sponsor Fees	8,484	57,653	4.04
5.00	0		0	7,408,187	8,622,363	5.00

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

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

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

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

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

6.00	B		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
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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/27/2022 8:10 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	350,567	0		1.00
2.00	-827,624	0		2.00
3.00	0	0		3.00
4.00	-566,817	0		4.00
4.02	-104,770	0		4.02
4.03	-16,363	0		4.03
4.04	-49,169	0		4.04
5.00	-1,214,176			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
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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8-2

Date/Time Prepared:
1/27/2022 8:10 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	219,839	0	219,839	211,500	2,314	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	DR. C	25,206	25,206	0	211,500	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	30.00	DR. E	704,897	704,897	0	211,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	30.00	DR. G	13,415	0	13,415	211,500	54	7.00
8.00	30.00	DR. H	6,250	0	6,250	211,500	25	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
13.00	30.00	DR. M	297,004	0	297,004	211,500	3,126	13.00
15.00	30.00	DR. O	20,445	20,445	0	211,500	0	15.00
16.00	30.00	DR. P	13,424	0	13,424	211,500	77	16.00
17.00	30.00	DR. Q	5,986	5,986	0	211,500	0	17.00
18.00	50.00	DR. R	73,868	73,868	0	239,400	0	18.00
19.00	50.00	DR. S	613	0	613	239,400	2	19.00
20.00	30.00	DR. T	172,799	172,799	0	211,500	0	20.00
21.00	30.00	DR. U	282,006	282,006	0	211,500	0	21.00
22.00	30.00	DR. V	145,348	145,348	0	211,500	0	22.00
23.00	30.00	DR. W	13,873	13,873	0	211,500	0	23.00
24.00	60.00	DR. X	7,376	0	7,376	260,300	39	24.00
25.00	50.00	DR. Y	9,634	0	9,634	239,400	36	25.00
26.00	50.00	DR. Z	145,220	145,220	0	239,400	0	26.00
27.00	30.00	DR. AA	139,985	139,985	0	211,500	0	27.00
28.00	30.00	DR. AB	87,943	87,943	0	211,500	0	28.00
29.00	30.00	DR. AC	11,488	11,488	0	211,500	0	29.00
200.00			2,396,619	1,829,064	567,555		5,673	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8-2

Date/Time Prepared:
1/27/2022 8:10 am

	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	235,294	11,765	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	30.00	DR. G	5,491	275	0	0	0	7.00
8.00	30.00	DR. H	2,542	127	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
13.00	30.00	DR. M	317,860	15,893	0	0	0	13.00
15.00	30.00	DR. O	0	0	0	0	0	15.00
16.00	30.00	DR. P	7,830	392	0	0	0	16.00
17.00	30.00	DR. Q	0	0	0	0	0	17.00
18.00	50.00	DR. R	0	0	0	0	0	18.00
19.00	50.00	DR. S	230	12	0	0	0	19.00
20.00	30.00	DR. T	0	0	0	0	0	20.00
21.00	30.00	DR. U	0	0	0	0	0	21.00
22.00	30.00	DR. V	0	0	0	0	0	22.00
23.00	30.00	DR. W	0	0	0	0	0	23.00
24.00	60.00	DR. X	4,881	244	0	0	0	24.00
25.00	50.00	DR. Y	4,144	207	0	0	0	25.00
26.00	50.00	DR. Z	0	0	0	0	0	26.00
27.00	30.00	DR. AA	0	0	0	0	0	27.00
28.00	30.00	DR. AB	0	0	0	0	0	28.00
29.00	30.00	DR. AC	0	0	0	0	0	29.00
200.00			578,272	28,915	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet A-8-2

Date/Time Prepared:
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	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	235,294	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	DR. C	0	0	0	25,206		3.00
4.00	0.00		0	0	0	0		4.00
5.00	30.00	DR. E	0	0	0	704,897		5.00
6.00	0.00		0	0	0	0		6.00
7.00	30.00	DR. G	0	5,491	7,924	7,924		7.00
8.00	30.00	DR. H	0	2,542	3,708	3,708		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
13.00	30.00	DR. M	0	317,860	0	0		13.00
15.00	30.00	DR. O	0	0	0	20,445		15.00
16.00	30.00	DR. P	0	7,830	5,594	5,594		16.00
17.00	30.00	DR. Q	0	0	0	5,986		17.00
18.00	50.00	DR. R	0	0	0	73,868		18.00
19.00	50.00	DR. S	0	230	383	383		19.00
20.00	30.00	DR. T	0	0	0	172,799		20.00
21.00	30.00	DR. U	0	0	0	282,006		21.00
22.00	30.00	DR. V	0	0	0	145,348		22.00
23.00	30.00	DR. W	0	0	0	13,873		23.00
24.00	60.00	DR. X	0	4,881	2,495	2,495		24.00
25.00	50.00	DR. Y	0	4,144	5,490	5,490		25.00
26.00	50.00	DR. Z	0	0	0	145,220		26.00
27.00	30.00	DR. AA	0	0	0	139,985		27.00
28.00	30.00	DR. AB	0	0	0	87,943		28.00
29.00	30.00	DR. AC	0	0	0	11,488		29.00
200.00			0	578,272	25,594	1,854,658		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
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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	5,176,788	5,176,788			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,297,579		1,297,579		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,294,544	150,488	37,720	3,482,752	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,280,764	740,836	185,693	315,326	5.00
7.00	00700	OPERATION OF PLANT	2,995,691	956,398	239,724	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	219,173	80,238	20,112	0	8.00
9.00	00900	HOUSEKEEPING	1,067,659	68,206	17,096	111,217	9.00
10.00	01000	DIETARY	1,041,901	279,450	70,045	110,201	10.00
11.00	01100	CAFETERIA	0	56,239	14,097	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,044,593	38,669	9,692	189,264	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,475	252,583	63,311	28,252	14.00
15.00	01500	PHARMACY	1,060,444	97,908	24,541	183,448	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	777,750	61,184	15,336	126,193	16.00
17.00	01700	SOCIAL SERVICE	835,936	15,955	3,999	148,490	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	15,936,120	1,599,987	401,044	1,538,250	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	654,246	192,882	48,346	84,244	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,155	70,711	17,724	36,723	54.00
60.00	06000	LABORATORY	1,284,441	74,898	18,773	95,188	60.00
65.00	06500	RESPIRATORY THERAPY	3,200,396	78,161	19,591	364,204	65.00
66.00	06600	PHYSICAL THERAPY	1,202,917	141,851	35,555	214	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	544,266	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,614,122	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,351,222	33,592	8,420	99,860	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)	60,289,182	4,990,236	1,250,819	3,431,074	60,004,192
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,944	4,999	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	64,410	0	0	11,322	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	155,927	39,084	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	220,113	10,681	2,677	40,356	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	260,957	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		TOTAL (sum lines 118 through 201)	60,834,662	5,176,788	1,297,579	3,482,752	60,834,662

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/27/2022 8:10 am

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	16,522,619					5.00
7.00	00700	OPERATION OF PLANT	1,590,085	5,781,898				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	121,205	139,357	580,085			8.00
9.00	00900	HOUSEKEEPING	479,542	118,459	0	1,862,179		9.00
10.00	01000	DIETARY	569,602	485,346	0	163,611	2,720,156	10.00
11.00	01100	CAFETERIA	26,681	97,676	0	32,927	1,536,731	11.00
13.00	01300	NURSING ADMINISTRATION	486,385	67,159	0	22,640	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	156,899	438,684	0	147,881	0	14.00
15.00	01500	PHARMACY	518,295	170,046	0	57,323	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	371,920	106,264	0	35,822	0	16.00
17.00	01700	SOCIAL SERVICE	380,992	27,711	0	9,341	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	7,387,608	2,778,846	580,085	936,754	1,167,755	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	371,637	334,996	0	112,928	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,128	122,811	0	41,400	0	54.00
60.00	06000	LABORATORY	558,868	130,082	0	43,851	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,389,244	135,750	0	45,762	0	65.00
66.00	06600	PHYSICAL THERAPY	523,680	246,366	0	83,050	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	206,457	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	612,287	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	566,377	58,342	0	19,667	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)	16,493,892	5,457,895	580,085	1,752,957	2,704,486	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,639	0	11,677	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	28,727	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	270,814	0	91,292	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	18,550	0	6,253	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	15,670	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)	16,522,619	5,781,898	580,085	1,862,179	2,720,156	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2008

Period:
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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	1,764,351					11.00
13.00	01300	NURSING ADMINISTRATION	96,942	1,955,344				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,314	0	1,189,399			14.00
15.00	01500	PHARMACY	90,480	0	19,162	2,221,647		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,480	0	968	0	1,585,917	16.00
17.00	01700	SOCIAL SERVICE	77,554	0	12	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	988,811	1,869,798	466,313	120,846	885,971	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	45,240	85,546	100,106	0	13,636	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,388	0	3,611	0	33,702	54.00
60.00	06000	LABORATORY	77,554	0	183,296	583	85,387	60.00
65.00	06500	RESPIRATORY THERAPY	200,348	0	119,327	0	233,855	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,988	0	40,262	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	251,817	0	8,775	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,100,218	258,083	73.00
74.00	07400	RENAL DIALYSIS	45,240	0	39,799	0	26,246	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)	1,764,351	1,955,344	1,189,399	2,221,647	1,585,917	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)	1,764,351	1,955,344	1,189,399	2,221,647	1,585,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2008

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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	1,499,990					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,499,990	0	38,158,178	0	38,158,178	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	2,043,807	0	2,043,807	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	861,353	0	861,353	54.00
60.00	06000	LABORATORY	0	0	2,552,921	0	2,552,921	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,786,638	0	5,786,638	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,278,883	0	2,278,883	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	1,011,315	0	1,011,315	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,584,710	0	4,584,710	73.00
74.00	07400	RENAL DIALYSIS	0	0	2,248,765	0	2,248,765	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	09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,499,990	0	59,526,570	0	59,526,570	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	71,259	0	71,259	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	104,459	0	104,459	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	557,117	0	557,117	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	298,630	0	298,630	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	260,957	0	260,957	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	15,670	0	15,670	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)	1,499,990	0	60,834,662	0	60,834,662	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	150,488	37,720	188,208	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	604,080	740,836	185,693	1,530,609	5.00
7.00	00700	OPERATION OF PLANT	0	956,398	239,724	1,196,122	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,238	20,112	100,350	8.00
9.00	00900	HOUSEKEEPING	0	68,206	17,096	85,302	9.00
10.00	01000	DIETARY	0	279,450	70,045	349,495	10.00
11.00	01100	CAFETERIA	0	56,239	14,097	70,336	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,669	9,692	48,361	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	252,583	63,311	315,894	14.00
15.00	01500	PHARMACY	0	97,908	24,541	122,449	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,184	15,336	76,520	16.00
17.00	01700	SOCIAL SERVICE	0	15,955	3,999	19,954	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	1,599,987	401,044	2,001,031	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	192,882	48,346	241,228	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,711	17,724	88,435	54.00
60.00	06000	LABORATORY	0	74,898	18,773	93,671	60.00
65.00	06500	RESPIRATORY THERAPY	0	78,161	19,591	97,752	65.00
66.00	06600	PHYSICAL THERAPY	0	141,851	35,555	177,406	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	33,592	8,420	42,012	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)	604,080	4,990,236	1,250,819	6,845,135	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,944	4,999	24,943	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	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	155,927	39,084	195,011	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	10,681	2,677	13,358	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)	604,080	5,176,788	1,297,579	7,078,447	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
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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	1,547,649					5.00
7.00	00700	OPERATION OF PLANT	148,939	1,345,061				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,353	32,419	144,122			8.00
9.00	00900	HOUSEKEEPING	44,918	27,558	0	163,788		9.00
10.00	01000	DIETARY	53,353	112,908	0	14,390	536,101	10.00
11.00	01100	CAFETERIA	2,499	22,723	0	2,896	302,866	11.00
13.00	01300	NURSING ADMINISTRATION	45,558	15,624	0	1,991	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,696	102,052	0	13,007	0	14.00
15.00	01500	PHARMACY	48,547	39,558	0	5,042	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,837	24,721	0	3,151	0	16.00
17.00	01700	SOCIAL SERVICE	35,687	6,447	0	822	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	691,996	646,451	144,122	82,391	230,147	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	34,810	77,931	0	9,933	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,498	28,570	0	3,641	0	54.00
60.00	06000	LABORATORY	52,348	30,261	0	3,857	0	60.00
65.00	06500	RESPIRATORY THERAPY	130,127	31,580	0	4,025	0	65.00
66.00	06600	PHYSICAL THERAPY	49,052	57,313	0	7,305	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	19,338	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,351	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	53,051	13,572	0	1,730	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)	1,544,958	1,269,688	144,122	154,181	533,013	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,058	0	1,027	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	2,691	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	63,000	0	8,030	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	4,315	0	550	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	3,088	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)	1,547,649	1,345,061	144,122	163,788	536,101	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet B
Part II
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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	401,320					11.00
13.00	01300	NURSING ADMINISTRATION	22,051	143,813				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,350	0	454,526			14.00
15.00	01500	PHARMACY	20,581	0	7,323	253,414		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,581	0	370	0	167,000	16.00
17.00	01700	SOCIAL SERVICE	17,640	0	4	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	224,916	137,521	178,202	13,784	93,306	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	10,290	6,292	38,255	0	1,436	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,410	0	1,380	0	3,548	54.00
60.00	06000	LABORATORY	17,640	0	70,046	66	8,990	60.00
65.00	06500	RESPIRATORY THERAPY	45,571	0	45,600	0	24,622	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,906	0	4,239	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	96,231	0	924	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	239,564	27,172	73.00
74.00	07400	RENAL DIALYSIS	10,290	0	15,209	0	2,763	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)	401,320	143,813	454,526	253,414	167,000	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)	401,320	143,813	454,526	253,414	167,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/27/2022 8:10 am

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	88,579					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	88,579		4,615,569	0	4,615,569	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		424,728	0	424,728	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		148,467	0	148,467	54.00
60.00	06000	LABORATORY	0		282,023	0	282,023	60.00
65.00	06500	RESPIRATORY THERAPY	0		398,959	0	398,959	65.00
66.00	06600	PHYSICAL THERAPY	0		297,233	0	297,233	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		116,493	0	116,493	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		324,087	0	324,087	73.00
74.00	07400	RENAL DIALYSIS	0		144,024	0	144,024	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)	88,579	0	6,751,583	0	6,751,583	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		34,028	0	34,028	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0		3,303	0	3,303	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		266,041	0	266,041	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		20,404	0	20,404	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		3,088	0	3,088	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)	88,579	0	7,078,447	0	7,078,447	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/27/2022 8:10 am

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	157,036				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		157,036			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,565	4,565	18,995,866		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,473	22,473	1,719,867	-16,522,619	5.00
7.00	00700	OPERATION OF PLANT	29,012	29,012	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,434	2,434	0	0	8.00
9.00	00900	HOUSEKEEPING	2,069	2,069	606,606	0	9.00
10.00	01000	DIETARY	8,477	8,477	601,067	0	10.00
11.00	01100	CAFETERIA	1,706	1,706	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,173	1,173	1,032,293	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,662	7,662	154,091	0	14.00
15.00	01500	PHARMACY	2,970	2,970	1,000,572	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,856	1,856	688,290	0	16.00
17.00	01700	SOCIAL SERVICE	484	484	809,902	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	48,535	48,535	8,390,056	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	5,851	5,851	459,488	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145	2,145	200,299	0	54.00
60.00	06000	LABORATORY	2,272	2,272	519,180	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,371	2,371	1,986,462	0	65.00
66.00	06600	PHYSICAL THERAPY	4,303	4,303	1,165	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	1,019	1,019	544,664	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)	151,377	151,377	18,714,002	-16,522,619	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	605	0	-24,943	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	61,751	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)	4,730	4,730	0	-195,011	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	324	324	220,113	-273,827	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	-260,957	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)	5,176,788	1,297,579	3,482,752		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.965613	8.262940	0.183343		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			188,208		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.009908		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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/27/2022 8:10 am

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	100,986				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,434	29,463			8.00
9.00	00900	HOUSEKEEPING	2,069		96,483		9.00
10.00	01000	DIETARY	8,477		8,477	124,988	10.00
11.00	01100	CAFETERIA	1,706		1,706	70,611	273 11.00
13.00	01300	NURSING ADMINISTRATION	1,173		1,173		15 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,662		7,662		5 14.00
15.00	01500	PHARMACY	2,970		2,970		14 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,856		1,856		14 16.00
17.00	01700	SOCIAL SERVICE	484		484		12 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	48,535	29,463	48,535	53,657	153 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	5,851	0	5,851	0	7 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145	0	2,145	0	3 54.00
60.00	06000	LABORATORY	2,272	0	2,272	0	12 60.00
65.00	06500	RESPIRATORY THERAPY	2,371	0	2,371	0	31 65.00
66.00	06600	PHYSICAL THERAPY	4,303	0	4,303	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	1,019	0	1,019	0	7 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)	95,327	29,463	90,824	124,268	273 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	0	605	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)	4,730	0	4,730	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	324	0	324	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	720	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)	5,781,898	580,085	1,862,179	2,720,156	1,764,351 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	57.254451	19.688592	19.300592	21.763337	6,462.824176 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,345,061	144,122	163,788	536,101	401,320 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.319282	4.891627	1.697584	4.289220	1,470.036630 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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/27/2022 8:10 am

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	160					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,570,717				14.00
15.00	01500	PHARMACY	0	41,415	1,707,446			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,092	0	224,719,654		16.00
17.00	01700	SOCIAL SERVICE	0	25	0	0	29,463	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	153	1,007,873	92,876	125,535,031	29,463	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	7	216,366	0	1,932,236	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,804	0	4,775,734	0	54.00
60.00	06000	LABORATORY	0	396,168	448	12,099,620	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	257,908	0	33,138,044	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,781	0	5,705,198	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	544,266	0	1,243,436	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,614,122	36,571,172	0	73.00
74.00	07400	RENAL DIALYSIS	0	86,019	0	3,719,183	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)	160	2,570,717	1,707,446	224,719,654	29,463	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)	1,955,344	1,189,399	2,221,647	1,585,917	1,499,990	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12,220.900000	0.462672	1.301152	0.007057	50.910973	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	143,813	454,526	253,414	167,000	88,579	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	898.831250	0.176809	0.148417	0.000743	3.006449	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/27/2022 8:10 am

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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/27/2022 8:10 am

				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	38,158,178		38,158,178	17,226	38,175,404	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	2,043,807		2,043,807	5,873	2,049,680	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	861,353		861,353	0	861,353	54.00	
60.00	06000	LABORATORY	2,552,921		2,552,921	2,495	2,555,416	60.00	
65.00	06500	RESPIRATORY THERAPY	5,786,638	0	5,786,638	0	5,786,638	65.00	
66.00	06600	PHYSICAL THERAPY	2,278,883	0	2,278,883	0	2,278,883	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	1,011,315		1,011,315	0	1,011,315	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,584,710		4,584,710	0	4,584,710	73.00	
74.00	07400	RENAL DIALYSIS	2,248,765		2,248,765	0	2,248,765	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)	59,526,570	0	59,526,570	25,594	59,552,164	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	59,526,570	0	59,526,570	25,594	59,552,164	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/27/2022 8:10 am

			Title XVIII		Hospital		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	125,535,031		125,535,031			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	1,895,186	37,050	1,932,236	1.057742	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,465,035	310,699	4,775,734	0.180360	0.000000	54.00
60.00	06000	LABORATORY	11,413,897	685,723	12,099,620	0.210992	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	33,027,394	110,650	33,138,044	0.174622	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,590,229	114,969	5,705,198	0.399440	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	1,237,620	5,816	1,243,436	0.813323	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,571,172	0	36,571,172	0.125364	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,523,131	196,052	3,719,183	0.604640	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)	223,258,695	1,460,959	224,719,654			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	223,258,695	1,460,959	224,719,654			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet C
Part I
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1/27/2022 8:10 am

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	1.060781		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180360		54.00
60.00	06000	LABORATORY	0.211198		60.00
65.00	06500	RESPIRATORY THERAPY	0.174622		65.00
66.00	06600	PHYSICAL THERAPY	0.399440		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	0.813323		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.125364		73.00
74.00	07400	RENAL DIALYSIS	0.604640		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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet C
Part I
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1/27/2022 8:10 am

				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	38,158,178		38,158,178	17,226	38,175,404	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	2,043,807		2,043,807	5,873	2,049,680	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	861,353		861,353	0	861,353	54.00	
60.00	06000	LABORATORY	2,552,921		2,552,921	2,495	2,555,416	60.00	
65.00	06500	RESPIRATORY THERAPY	5,786,638	0	5,786,638	0	5,786,638	65.00	
66.00	06600	PHYSICAL THERAPY	2,278,883	0	2,278,883	0	2,278,883	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	1,011,315		1,011,315	0	1,011,315	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,584,710		4,584,710	0	4,584,710	73.00	
74.00	07400	RENAL DIALYSIS	2,248,765		2,248,765	0	2,248,765	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)	59,526,570	0	59,526,570	25,594	59,552,164	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	59,526,570	0	59,526,570	25,594	59,552,164	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet C
Part I
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			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	125,535,031		125,535,031			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	1,895,186	37,050	1,932,236	1.057742	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,465,035	310,699	4,775,734	0.180360	0.000000	54.00
60.00	06000	LABORATORY	11,413,897	685,723	12,099,620	0.210992	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	33,027,394	110,650	33,138,044	0.174622	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,590,229	114,969	5,705,198	0.399440	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	1,237,620	5,816	1,243,436	0.813323	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,571,172	0	36,571,172	0.125364	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,523,131	196,052	3,719,183	0.604640	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)	223,258,695	1,460,959	224,719,654			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	223,258,695	1,460,959	224,719,654			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
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: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet D Part I Date/Time Prepared: 1/27/2022 8:10 am			
				Title XVIII		Hospital		PPS	
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	4,615,569	0	4,615,569	29,463	156.66	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)	4,615,569		4,615,569	29,463		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	7,383	1,156,621						
31.00	INTENSIVE CARE UNIT	0	0						
44.00	SKILLED NURSING FACILITY	0	0						
200.00	Total (lines 30 through 199)	7,383	1,156,621						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet D
Part II
Date/Time Prepared:
1/27/2022 8:10 am

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	424,728	1,932,236	0.219812	422,138	92,791
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,467	4,775,734	0.031088	1,193,309	37,098
60.00	06000	LABORATORY	282,023	12,099,620	0.023308	3,582,725	83,506
65.00	06500	RESPIRATORY THERAPY	398,959	33,138,044	0.012039	9,607,355	115,663
66.00	06600	PHYSICAL THERAPY	297,233	5,705,198	0.052099	1,527,647	79,589
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	116,493	1,243,436	0.093686	372,500	34,898
73.00	07300	DRUGS CHARGED TO PATIENTS	324,087	36,571,172	0.008862	9,591,927	85,004
74.00	07400	RENAL DIALYSIS	144,024	3,719,183	0.038725	1,056,158	40,900
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)	2,136,014	99,184,623		27,353,759	569,449

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet D Part III Date/Time Prepared: 1/27/2022 8:10 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	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	29,463	0.00	7,383	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	29,463		7,383	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D
Part IV
Date/Time Prepared:
1/27/2022 8:10 am

				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	1,932,236	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,775,734	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	12,099,620	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	33,138,044	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	5,705,198	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	1,243,436	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,571,172	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	3,719,183	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	0	0	0	0	0.000000	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	99,184,623		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description			Title XVIII		Hospital		PPS
			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	422,138	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,193,309	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	3,582,725	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,607,355	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,527,647	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	372,500	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,591,927	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,056,158	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	0.000000	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0 98.00
200.00		Total (lines 50 through 199)		27,353,759	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/27/2022 8:10 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1.057742	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180360	0	292,319	0	0	54.00
60.00	06000	LABORATORY	0.210992	0	20,721	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.174622	0	110,650	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.399440	0	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	0.813323	0	5,730	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.125364	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.604640	0	196,052	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	0.000000	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	625,472	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	625,472	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/27/2022 8:10 am

				Title XVIII	Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,723	0		54.00
60.00	06000	LABORATORY	4,372	0		60.00
65.00	06500	RESPIRATORY THERAPY	19,322	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		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	4,660	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	118,541	0		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			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	199,618	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	199,618	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/27/2022 8:10 am	
		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)			29,463	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			29,463	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)			29,463	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)			7,383	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)			38,175,404	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)			38,175,404	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)			38,175,404	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)			1,295.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			9,566,227	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)			9,566,227	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/27/2022 8:10 am

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)					5,851,584	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,417,811	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)					1,156,621	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					569,449	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,726,070	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,691,741	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:14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet D-1 Date/Time Prepared: 1/27/2022 8:10 am	
				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	4,615,569	38,175,404	0.120904	0	0			90.00
91.00	Nursing Program cost	0	38,175,404	0.000000	0	0			91.00
92.00	Allied health cost	0	38,175,404	0.000000	0	0			92.00
93.00	All other Medical Education	0	38,175,404	0.000000	0	0			93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/27/2022 8:10 am
		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)		29,463	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		29,463	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)		29,463	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)		2,903	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)		38,158,178	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)		38,158,178	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)		38,158,178	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)		1,295.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,759,733	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,759,733	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/27/2022 8:10 am

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)					1,808,720	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,568,453	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:14-2008		Period: From 12/16/2020 To 08/31/2021		Worksheet D-1 Date/Time Prepared: 1/27/2022 8:10 am	
				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	4,615,569	38,158,178	0.120959	0	0	90.00		
91.00	Nursing Program cost	0	38,158,178	0.000000	0	0	91.00		
92.00	Allied health cost	0	38,158,178	0.000000	0	0	92.00		
93.00	All other Medical Education	0	38,158,178	0.000000	0	0	93.00		

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D-2

Date/Time Prepared:
1/27/2022 8:10 am

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	29,463	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	29,463	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D-2

Date/Time Prepared:
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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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D-2

Date/Time Prepared:
1/27/2022 8:10 am

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	7,383	2,903	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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet D-2

Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs		10/1/2022 - 9/30/2023	Amount
	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: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/27/2022 8:10 am	
			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		31,566,048		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.060781	422,138	447,796	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180360	1,193,309	215,225	54.00
60.00	06000	LABORATORY	0.211198	3,582,725	756,664	60.00
65.00	06500	RESPIRATORY THERAPY	0.174622	9,607,355	1,677,656	65.00
66.00	06600	PHYSICAL THERAPY	0.399440	1,527,647	610,203	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	0.813323	372,500	302,963	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.125364	9,591,927	1,202,482	73.00
74.00	07400	RENAL DIALYSIS	0.604640	1,056,158	638,595	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)		27,353,759	5,851,584	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)		27,353,759		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/27/2022 8:10 am	
			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		12,345,091		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.057742	139,031	147,059	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180360	212,093	38,253	54.00
60.00	06000	LABORATORY	0.210992	782,567	165,115	60.00
65.00	06500	RESPIRATORY THERAPY	0.174622	3,664,418	639,888	65.00
66.00	06600	PHYSICAL THERAPY	0.399440	440,341	175,890	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	0.813323	131,532	106,978	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.125364	3,554,888	445,655	73.00
74.00	07400	RENAL DIALYSIS	0.604640	148,654	89,882	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)		9,073,524	1,808,720	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)		9,073,524		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet E Part B Date/Time Prepared: 1/27/2022 8:10 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		199,618	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		199,618	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		625,472	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		625,472	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		625,472	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		425,854	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		199,618	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		125,094	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		74,524	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		74,524	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		74,524	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		74,524	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		74,524	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		49,803	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		24,721	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet E-1
Part I
Date/Time Prepared:
1/27/2022 8:10 am

		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		13,405,431		49,803	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	05/25/2021	1,049,800		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)		1,049,800		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)		14,455,231		49,803	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		143,746		24,721	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		14,598,977		74,524	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: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet E-3 Part IV Date/Time Prepared: 1/27/2022 8:10 am
		Title XVIII	Hospital	PPS
		1.00		
	PART IV - MEDICARE PART A SERVICES - LTCH PPS			
1.00	Net Federal PPS Payments (see instructions)	14,233,011	1.00	
1.01	Full standard payment amount	10,402,088	1.01	
1.02	Short stay outlier standard payment amount	3,830,923	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	1,165,884	2.00	
3.00	Total PPS Payments (sum of lines 1 and 2)	15,398,895	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)	0	5.00	
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00	
7.00	Subtotal (see instructions)	15,398,895	7.00	
8.00	Primary payer payments	143,160	8.00	
9.00	Subtotal (line 7 less line 8).	15,255,735	9.00	
10.00	Deductibles	51,636	10.00	
11.00	Subtotal (line 9 minus line 10)	15,204,099	11.00	
12.00	Coinsurance	1,319,928	12.00	
13.00	Subtotal (line 11 minus line 12)	13,884,171	13.00	
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,099,701	14.00	
15.00	Adjusted reimbursable bad debts (see instructions)	714,806	15.00	
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	869,599	16.00	
17.00	Subtotal (sum of lines 13 and 15)	14,598,977	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	
21.98	Recovery of accelerated depreciation.	0	21.98	
21.99	Demonstration payment adjustment amount before sequestration	0	21.99	
22.00	Total amount payable to the provider (see instructions)	14,598,977	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	14,455,231	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)	143,746	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)	1,165,884	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: 14-2008	Period: From 12/16/2020 To 08/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 1/27/2022 8:10 am	
		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		5,568,453		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)		5,568,453	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)		5,568,453	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		12,345,091		8.00
9.00	Ancillary service charges		9,073,524	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)		21,418,615	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)		21,418,615	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		15,850,162	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)		5,568,453	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)		5,568,453	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)		5,568,453	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)		5,568,453	0	36.00
37.00	OTHER ADJUSTMENTS		0		37.00
37.01	OTHER ADJUSTMENTS		0		37.01
38.00	Subtotal (line 36 ± line 37)		5,568,453	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)		5,568,453	0	40.00
41.00	Interim payments		3,081,090		41.00
42.00	Balance due provider/program (line 40 minus line 41)		2,487,363		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: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet G

Date/Time Prepared:
1/27/2022 8:10 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-414,269	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	45,892,795	0	0	0	4.00
5.00	Other receivable	21,995	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,113,871	0	0	0	6.00
7.00	Inventory	1,520,311	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)	34,906,961	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,806,129	0	0	0	12.00
13.00	Land improvements	25,774	0	0	0	13.00
14.00	Accumulated depreciation	-25,774	0	0	0	14.00
15.00	Buildings	1,127,463	0	0	0	15.00
16.00	Accumulated depreciation	-749,626	0	0	0	16.00
17.00	Leasehold improvements	6,955,949	0	0	0	17.00
18.00	Accumulated depreciation	-2,568,255	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	6,672,813	0	0	0	23.00
24.00	Accumulated depreciation	-1,914,633	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)	14,329,840	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	22,020,614	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,020,614	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,257,415	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,900,299	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,435,582	0	0	0	38.00
39.00	Payroll taxes payable	386,362	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	51,517,566	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	61,239,809	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	-106,803	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-106,803	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	61,133,006	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,124,409				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,124,409	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,257,415	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet G-1

Date/Time Prepared:
1/27/2022 8:10 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,913,214		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,584,295				2.00
3.00	Total (sum of line 1 and line 2)		10,497,509		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)		10,497,509		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	373,100		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)		373,100		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,124,409		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: 14-2008

Period:
From 12/16/2020
To 08/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
1/27/2022 8:10 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	125,535,031		125,535,031	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)	125,535,031		125,535,031	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)	125,535,031		125,535,031	17.00
18.00	Ancillary services	97,723,664	1,460,959	99,184,623	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)	223,258,695	1,460,959	224,719,654	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		65,361,572		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)		65,361,572		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2008

Period:
From 12/16/2020
To 08/31/2021

Worksheet G-3

Date/Time Prepared:
1/27/2022 8:10 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	224,719,654	1.00
2.00	Less contractual allowances and discounts on patients' accounts	156,494,563	2.00
3.00	Net patient revenues (line 1 minus line 2)	68,225,091	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	65,361,572	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,863,519	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	437	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	9,484	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	-2,322	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	713,177	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	720,776	25.00
26.00	Total (line 5 plus line 25)	3,584,295	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)	3,584,295	29.00