

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 12:01 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/29/2021	Time: 12:01 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LINDEN OAKS HOSPITAL (14-4035) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DENISE CHAMBERLAIN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	57,128	1,139	0	117,132	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
200.00	Total	0	57,128	1,139	0	117,132	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: 14-4035		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:01 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 852 WEST STREET			PO Box:				1.00	
2.00	City: NAPERVILLE			State: IL		Zip Code: 60540		County: DUPAGE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LINDEN OAKS HOSPITAL	144035	16980	4	06/01/1992	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y			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)		N	N	0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		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.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:01 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	395,040 118.01
		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
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	14H131	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4035		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:01 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: EDWARD ELMHURST HEALTH		Contractor's Name: NGS		Contractor's Number: 00131				141.00
142.00	Street: 4201 WINFIELD RD		PO Box:						142.00
143.00	City: WARRENVILLE		State: IL		Zip Code: 60555				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.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
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	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 12:01 pm

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/21/2021	Y
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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 12:01 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		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.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
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Date/Time Prepared:
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		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.	CONSULTANT	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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	110	40,150	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)		110	40,150	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		110	40,150	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						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)		110			0	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)		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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,033	300	25,293			1.00
2.00	HMO and other (see instructions)	0	342				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)	3,033	300	25,293			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,033	300	25,293	0.00	451.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	451.62	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	235	42	3,475	1.00
2.00 HMO and other (see instructions)			0	31		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	235	42	3,475	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/29/2021 12:01 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	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)	0	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	0	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	0	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-4035

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

Worksheet S-5

Date/Time Prepared:
11/29/2021 12:01 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	0	0					5.00
6.00	Number of stations	0	0	0	0			6.00
7.00	Treatment capacity per day per station	0	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00
							Y/N	
							1.00	
ESRD PPS								
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02
						Prior to 1/1	After 12/31	
						1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	4
TRANSPLANT INFORMATION								
11.00	Number of patients on transplant list						0	11.00
12.00	Number of patients transplanted during the cost reporting period						0	12.00
EPOETIN								
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.							13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program							14.00
15.00	Number of EPO units furnished relating to the renal dialysis department							15.00
16.00	Number of EPO units furnished relating to the home dialysis department							16.00
ARANESP								
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.							17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program							18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department							19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department							20.00
						MCP	INITIAL METHOD	
						1.00	2.00	
PHYSICIAN PAYMENT METHOD								
21.00	Enter "X" if method(s) is applicable							21.00
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.		
		1.00	2.00	3.00	4.00	5.00		
ESAs								
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00	

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-4035

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

Worksheet S-5

Date/Time Prepared:
11/29/2021 12:01 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4035

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

Worksheet A

Date/Time Prepared:
11/29/2021 12:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	11/29/2021 12:01 pm
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,153,386	1,153,386	84,805	1,238,191	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		231,830	231,830	110,805	342,635	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,885,300	4,885,300	3,346,466	8,231,766	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,674,014	19,240,877	26,914,891	-3,898,347	23,016,544	5.00
7.00	00700	OPERATION OF PLANT	0	709,872	709,872	0	709,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	611,248	350,329	961,577	0	961,577	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,382,321	23,598	1,405,919	-162	1,405,757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	341,250	314,750	656,000	-312,152	343,848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,211,657	324,859	14,536,516	-13,919	14,522,597	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	489,636	489,636	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	204,097	204,097	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	7,790,351	2,383,319	10,173,670	-11,229	10,162,441	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	61,242	65,895	127,137	0	127,137	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,072,083	29,684,015	61,756,098	0	61,756,098	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	70,675	0	70,675	0	70,675	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	32,142,758	29,684,015	61,826,773	0	61,826,773	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet A
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,238,191	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	138,399	481,034	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,246,018	9,477,784	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,771,589	14,244,955	5.00
7.00	00700	OPERATION OF PLANT	1,465,294	2,175,166	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	664,233	664,233	9.00
10.00	01000	DIETARY	-66,858	894,719	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-361,044	1,044,713	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	343,848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,165	113,165	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-11,740	14,510,857	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	489,636	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	204,097	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	PARTIAL HOSPITALIZATION	265	10,162,706	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	127,137	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,583,857	56,172,241	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	ARABELLA	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	0	70,675	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,583,857	56,242,916	200.00

RECLASSIFICATIONS

Provider CCN: 14-4035

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

Worksheet A-6

Date/Time Prepared:
11/29/2021 12:01 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	110,805	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	110,805	
B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,346,466	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	3,346,466	
C - REAL ESTATE TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	84,805	1.00
	TOTALS		0	84,805	
D - DRUGS CHARGED					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	204,097	1.00
	TOTALS		0	204,097	
F - LAB SERVICES					
1.00	LABORATORY	60.00	0	489,636	1.00
	TOTALS		0	489,636	
500.00	Grand Total: Increases		0	4,235,809	500.00

RECLASSIFICATIONS

Provider CCN: 14-4035

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

Worksheet A-6

Date/Time Prepared:
11/29/2021 12:01 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	940	10	1.00
2.00	NURSING ADMINISTRATION	13.00	0	162	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,153	0	3.00
4.00	PARTIAL HOSPITALIZATION	90.01	0	1,099	0	4.00
5.00	PHARMACY	15.00	0	107,451	0	5.00
	TOTALS		0	110,805		
B - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,322,966	0	1.00
2.00	PHARMACY	15.00	0	604	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	12,766	0	3.00
4.00	PARTIAL HOSPITALIZATION	90.01	0	10,130	0	4.00
	TOTALS		0	3,346,466		
C - REAL ESTATE TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,805	13	1.00
	TOTALS		0	84,805		
D - DRUGS CHARGED						
1.00	PHARMACY	15.00	0	204,097	0	1.00
	TOTALS		0	204,097		
F - LAB SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	489,636	0	1.00
	TOTALS		0	489,636		
500.00	Grand Total: Decreases		0	4,235,809		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,220,416	19,188	0	19,188	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	27,525,221	383,286	0	383,286	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,292,890	92,460	0	92,460	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,038,527	494,934	0	494,934	0	8.00
9.00	Reconciling Items	0	1,954,443	0	1,954,443	0	9.00
10.00	Total (line 8 minus line 9)	34,038,527	-1,459,509	0	-1,459,509	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,239,604	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	27,908,507	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,385,350	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	34,533,461	0				8.00
9.00	Reconciling Items	1,954,443	0				9.00
10.00	Total (line 8 minus line 9)	32,579,018	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,153,386	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	231,830	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,385,216	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,153,386				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	231,830				2.00
3.00	Total (sum of lines 1-2)	0	1,385,216				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	27,908,507	0	27,908,507	0.838248	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,385,350	0	5,385,350	0.161752	0	2.00
3.00	Total (sum of lines 1-2)	33,293,857	0	33,293,857	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,153,386	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	370,229	110,805	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,523,615	110,805	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	84,805	0	1,238,191	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	481,034	2.00
3.00	Total (sum of lines 1-2)	0	0	84,805	0	1,719,225	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4035

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-602,916			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	-2,412,159			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OPERATING REVENUE	B	-2,105,241	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4035

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	OTHER OPERATING REVENUE	B	-66,858	DIETARY	10.00	0	34.00
35.00	OTHER OPERATING REVENUE	B	-361,044	NURSING ADMINISTRATION	13.00	0	35.00
36.00	OTHER OPERATING REVENUE	B	-11,740	ADULTS & PEDIATRICS	30.00	0	36.00
38.00	OTHER OPERATING REVENUE	B	265	PARTIAL HOSPITALIZATION	90.01	0	38.00
40.00	MARKETING	A	-23,914	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.01
40.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.02
41.00	CONTRIBUTIONS	A	-250	ADMINISTRATIVE & GENERAL	5.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,583,857				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: 14-4035

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 12:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	138,399	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	1,246,018	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	A & G	3,125,565	9,538,016	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	PATIENT ACCOUNTS	209,680	0	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	PATIENT ACCESS	163,503	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	113,165	0	3.04
3.05	7.00	OPERATION OF PLANT	OP PLANT	1,465,294	0	3.05
3.06	60.00	LABORATORY	LAB SERVICES	489,636	489,636	3.06
3.07	9.00	HOUSEKEEPING	HOUSEKEEPING ALLOC FROM EH	664,233	0	3.07
3.08	0.00			0	0	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,615,493	10,027,652	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	EDWARD ELMHURST HEALTH	100.00		0.00	6.00
7.00	C	EDWARD HEALTH V	100.00		0.00	7.00
8.00	B	EDWARD HOSPITAL	100.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-4035

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 12:01 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	9		1.00
2.00	138,399	9		2.00
3.00	1,246,018	0		3.00
3.01	-6,412,451	0		3.01
3.02	209,680	0		3.02
3.03	163,503	0		3.03
3.04	113,165	0		3.04
3.05	1,465,294	0		3.05
3.06	0	0		3.06
3.07	664,233	0		3.07
3.08	0	0		3.08
4.00	0	0		4.00
5.00	-2,412,159			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-4035

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 12:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	113,280	113,280	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	489,636	489,636	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			602,916	602,916	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	113,280		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	489,636		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	602,916		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,238,191	1,238,191				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	481,034		481,034			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,477,784	0	0	9,477,784		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,244,955	71,402	27,740	2,262,798	16,606,895	5.00
7.00	00700	OPERATION OF PLANT	2,175,166	667,380	259,276	0	3,101,822	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	664,233	0	0	0	664,233	9.00
10.00	01000	DIETARY	894,719	42,418	16,479	180,236	1,133,852	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,044,713	0	0	407,598	1,452,311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	343,848	3,696	1,436	100,623	449,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,165	0	0	0	113,165	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,510,857	347,568	135,029	4,190,529	19,183,983	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	489,636	2,632	1,022	0	493,290	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	204,097	0	0	0	204,097	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	10,162,706	103,095	40,052	2,297,102	12,602,955	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	127,137	0	0	18,058	145,195	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,172,241	1,238,191	481,034	9,456,944	56,151,401	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	70,675	0	0	20,840	91,515	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,242,916	1,238,191	481,034	9,477,784	56,242,916	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,606,895					5.00
7.00	00700	OPERATION OF PLANT	1,299,617	4,401,439				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	278,304	0	0	942,537		9.00
10.00	01000	DIETARY	475,067	373,842	0	80,056	2,062,817	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	608,497	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	188,377	32,571	0	6,975	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,414	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,037,797	3,063,224	0	655,967	2,062,817	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	206,681	23,196	0	4,967	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,514	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	5,280,449	908,606	0	194,572	0	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	60,835	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,568,552	4,401,439	0	942,537	2,062,817	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	38,343	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,606,895	4,401,439	0	942,537	2,062,817	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	2,060,808				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	677,526		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	160,579	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,321,791	0	0	73,031	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0	6,793	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	677,526	8,676	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	0	739,017	0	0	71,428	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	0	651	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,060,808	0	677,526	160,579	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,060,808	0	677,526	160,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,398,610	0	34,398,610	30.00
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	734,927	0	734,927	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	975,813	0	975,813	73.00
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	PARTIAL HOSPITALIZATION	19,797,027	0	19,797,027	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	206,681	0	206,681	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,113,058	0	56,113,058	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	ARABELLA	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	129,858	0	129,858	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,242,916	0	56,242,916	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	71,402	27,740	99,142	0 5.00
7.00	00700	OPERATION OF PLANT	0	667,380	259,276	926,656	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0 9.00
10.00	01000	DIETARY	0	42,418	16,479	58,897	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	3,696	1,436	5,132	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	347,568	135,029	482,597	0 30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	2,632	1,022	3,654	0 60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	PARTIAL HOSPITALIZATION	0	103,095	40,052	143,147	0 90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	0	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,238,191	481,034	1,719,225	0 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	ARABELLA	0	0	0	0	0 194.00
194.01	07951	NORTHWEST COMMUNITY	0	0	0	0	0 194.01
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,238,191	481,034	1,719,225	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	99,142					5.00
7.00	00700	OPERATION OF PLANT	7,758	934,414				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	1,661	0	0	1,661		9.00
10.00	01000	DIETARY	2,836	79,366	0	141	141,240	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,632	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,124	6,915	0	12	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,992	650,314	0	1,156	141,240	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	1,234	4,924	0	9	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	31,520	192,895	0	343	0	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	363	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,913	934,414	0	1,661	141,240	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	229	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	99,142	934,414	0	1,661	141,240	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	3,632				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	13,183		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	283	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,329	0	0	146	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0	11	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,183	14	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	0	1,303	0	0	111	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	0	1	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,632	0	13,183	283	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,632	0	13,183	283	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,325,774	0	1,325,774	30.00
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	9,832	0	9,832	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,707	0	13,707	73.00
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	PARTIAL HOSPITALIZATION	369,319	0	369,319	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	364	0	364	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,718,996	0	1,718,996	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	ARABELLA	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	229	0	229	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,719,225	0	1,719,225	202.00

COST ALLOCATION - STATISTICAL BASIS

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Period:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,908					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		112,908				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	32,142,758			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,511	6,511	7,674,014	-16,606,895	39,636,021	5.00
7.00	00700	OPERATION OF PLANT	60,857	60,857	0	0	3,101,822	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	664,233	9.00
10.00	01000	DIETARY	3,868	3,868	611,248	0	1,133,852	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,382,321	0	1,452,311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	337	337	341,250	0	449,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	113,165	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,694	31,694	14,211,657	0	19,183,983	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	240	240	0	0	493,290	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	204,097	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	9,401	9,401	7,790,351	0	12,602,955	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	61,242	0	145,195	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,908	112,908	32,072,083	-16,606,895	39,544,506	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	0	0	70,675	0	91,515	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,238,191	481,034	9,477,784		16,606,895	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.966371	4.260407	0.294865		0.418985	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		99,142	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002501	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

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Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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	45,540					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	0	0	45,540			9.00
10.00	01000	DIETARY	3,868	0	3,868	100		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	337	0	337	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,694	0	31,694	100	0	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	240	0	240	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	9,401	0	9,401	0	0	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,540	0	45,540	100	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	ARABELLA	0	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,401,439	0	942,537	2,062,817	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	96.649956	0.000000	20.696904	20,628.170000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	934,414	0	1,661	141,240	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.518533	0.000000	0.036473	1,412.400000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

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Period:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)		
		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					11.00
13.00	01300	NURSING ADMINISTRATION	691,473				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0			14.00
15.00	01500	PHARMACY	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	125,193,876	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	443,507	0	0	56,957,442	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	5,294,513	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	6,762,200	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	PARTIAL HOSPITALIZATION	247,966	0	0	55,672,452	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	507,269	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	691,473	0	100	125,193,876	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	ARABELLA	0	0	0	0	194.00
194.01	07951	NORTHWEST COMMUNITY	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,060,808	0	677,526	160,579	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.980316	0.000000	6,775.260000	0.001283	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,632	0	13,183	283	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005253	0.000000	131.830000	0.000002	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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,398,610		34,398,610	0	34,398,610	30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	734,927		734,927	0	734,927	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	975,813		975,813	0	975,813	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	PARTIAL HOSPITALIZATION	19,797,027		19,797,027	0	19,797,027	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	206,681		206,681	0	206,681	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
200.00		Subtotal (see instructions)	56,113,058	0	56,113,058	0	56,113,058	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	56,113,058	0	56,113,058	0	56,113,058	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4035

Period:
From 07/01/2020
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			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	56,957,442		56,957,442			30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	4,949,976	344,537	5,294,513	0.138809	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,762,200	0	6,762,200	0.144304	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	PARTIAL HOSPITALIZATION	0	55,672,452	55,672,452	0.355598	0.000000	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	507,269	507,269	0.407439	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	68,669,618	56,524,258	125,193,876			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	68,669,618	56,524,258	125,193,876			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.138809			60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.144304			73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 PARTIAL HOSPITALIZATION	0.355598			90.01
90.02	09002 TRANSCRANIAL MAG STIM (TMS)	0.407439			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

				Title XIX	Hospital	Cost			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	34,398,610		34,398,610	0	34,398,610	30.00	
ANCILLARY SERVICE COST CENTERS									
60.00	06000	LABORATORY	734,927		734,927	0	734,927	60.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	975,813		975,813	0	975,813	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	PARTIAL HOSPITALIZATION	19,797,027		19,797,027	0	19,797,027	90.01	
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	206,681		206,681	0	206,681	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00	
200.00		Subtotal (see instructions)	56,113,058	0	56,113,058	0	56,113,058	200.00	
201.00		Less Observation Beds	0		0	0	0	201.00	
202.00		Total (see instructions)	56,113,058	0	56,113,058	0	56,113,058	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,957,442		56,957,442			30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	4,949,976	344,537	5,294,513	0.138809	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,762,200	0	6,762,200	0.144304	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	PARTIAL HOSPITALIZATION	0	55,672,452	55,672,452	0.355598	0.000000	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	507,269	507,269	0.407439	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	68,669,618	56,524,258	125,193,876			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	68,669,618	56,524,258	125,193,876			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000			60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 PARTIAL HOSPITALIZATION	0.000000			90.01
90.02	09002 TRANSCRANIAL MAG STIM (TMS)	0.000000			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,325,774	0	1,325,774	25,293	52.42	30.00
200.00	Total (lines 30 through 199)		1,325,774		1,325,774	25,293		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		3,033	158,990				
200.00	Total (lines 30 through 199)		3,033	158,990				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	9,832	5,294,513	0.001857	488,913	908	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,707	6,762,200	0.002027	1,375,677	2,788	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	PARTIAL HOSPITALIZATION	369,319	55,672,452	0.006634	0	0	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	364	507,269	0.000718	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	393,222	68,236,434		1,864,590	3,696	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-4035		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 12:01 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
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	25,293	0.00	3,033	30.00		
200.00		Total (lines 30 through 199)		0	25,293		3,033	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	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-4035		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 12:01 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	0	0	0	0	0	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-4035		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 12:01 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	5,294,513	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,762,200	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	0	0	0	55,672,452	0.000000	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0	0	507,269	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	68,236,434		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-4035		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 12:01 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
60.00	06000	LABORATORY		0.000000	488,913	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,375,677	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	PARTIAL HOSPITALIZATION		0.000000	0	0	13,137	0	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)		0.000000	0	0	92,340	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,864,590	0	105,477	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 12:01 pm

			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								
60.00	06000	LABORATORY	0.138809	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.144304	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PARTIAL HOSPITALIZATION	0.355598	13,137	0	5,304	4,671	90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0.407439	92,340	0	0	37,623	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		105,477	0	5,304	42,294	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		105,477	0	5,304	42,294	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 12:01 pm

				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					
60.00	06000	LABORATORY	0	0		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	PARTIAL HOSPITALIZATION	0	1,886		90.01
90.02	09002	TRANSCRANIAL MAG STIM (TMS)	0	0		90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	1,886		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,886		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4035

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:01 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,293	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,293	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)	25,293	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)	3,033	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)	34,398,610	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)	34,398,610	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)	34,398,610	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)	1,360.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,124,910	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)	4,124,910	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4035

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					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)					266,382 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,391,292 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)					158,990 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,696 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					162,686 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,228,606 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: 14-4035

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,325,774	34,398,610	0.038541	0	90.00
91.00	Nursing School cost	0	34,398,610	0.000000	0	91.00
92.00	Allied health cost	0	34,398,610	0.000000	0	92.00
93.00	All other Medical Education	0	34,398,610	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 12:01 pm	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			25,293	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			25,293	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)			25,293	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)			300	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)			34,398,610	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)			34,398,610	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)			34,398,610	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)			1,360.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			408,003	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)			408,003	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4035

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Title XIX		Hospital		Program Cost (col. 3 x col. 4)	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days		
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					16,589	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					424,592	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: 14-4035

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,325,774	34,398,610	0.038541	0	0	90.00
91.00	Nursing School cost	0	34,398,610	0.000000	0	0	91.00
92.00	Allied health cost	0	34,398,610	0.000000	0	0	92.00
93.00	All other Medical Education	0	34,398,610	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 12:01 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		7,387,384		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.138809	488,913	67,866	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.144304	1,375,677	198,516	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 PARTIAL HOSPITALIZATION	0.355598	0	0	90.01
90.02	09002 TRANSCRANIAL MAG STIM (TMS)	0.407439	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,864,590	266,382	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,864,590		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 12:01 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,078,295		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.138809	56,965	7,907	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.144304	60,167	8,682	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 PARTIAL HOSPITALIZATION	0.355598	0	0	90.01
90.02	09002 TRANSCRANIAL MAG STIM (TMS)	0.407439	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		117,132	16,589	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)		117,132		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 12:01 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,886	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		42,294	2.00
3.00	OPPS payments		52,370	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)		1,886	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,304	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)		5,304	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)		5,304	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,418	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)		1,886	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)		52,370	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		10,364	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)		43,892	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)		43,892	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		43,892	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)		15	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		10	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		43,902	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)		43,902	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		42,763	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		1,139	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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 12:01 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,759,619		42,763	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			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)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,759,619		42,763	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		57,128		1,139	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,816,747		43,902	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: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/29/2021 12:01 pm
		Title XVIII	Hospital	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,948,338 1.00
2.00	Net IPF PPS Outlier Payments			70,137 2.00
3.00	Net IPF PPS ECT Payments			61,618 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			69.295890 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 -1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			3,080,093 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			3,080,093 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			3,080,093 18.00
19.00	Deductibles			197,304 19.00
20.00	Subtotal (line 18 minus line 19)			2,882,789 20.00
21.00	Coinurance			123,169 21.00
22.00	Subtotal (line 20 minus line 21)			2,759,620 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			87,887 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			57,127 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,816,747 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,816,747 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,759,619 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			57,128 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			70,137 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			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4035	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2021 12:01 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	424,592			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)	424,592		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)	424,592		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	117,132		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)	117,132		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)	117,132		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	307,460		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)	117,132		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)	117,132		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	307,460		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	117,132		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		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)	117,132		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	117,132		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)	117,132		0	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	117,132		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		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: 14-4035

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

Worksheet G

Date/Time Prepared:
11/29/2021 12:01 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	-5,265	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	4,797,444	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	119,997	0	0	0	7.00
8.00 Prepaid expenses	277,044	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	5,189,220	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,239,604	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	27,839,103	0	0	0	15.00
16.00 Accumulated depreciation	-18,788,935	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	13,328,627	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	23,618,399	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	333,488	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	333,488	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	29,141,107	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,102,724	0	0	0	37.00
38.00 Salaries, wages, and fees payable	4,736,566	0	0	0	38.00
39.00 Payroll taxes payable	0	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	8,310,721	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	14,150,011	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	7,475,937	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	471,349	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	7,947,286	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	22,097,297	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	7,043,810	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	7,043,810	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	29,141,107	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4035

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

Worksheet G-1

Date/Time Prepared:
11/29/2021 12:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,543,567		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,237,887				2.00
3.00	Total (sum of line 1 and line 2)		8,305,680		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICETD NET ASSETS	333,488		0		0	5.00
6.00	TRANSFER TO AFFILIATES	0		0		0	6.00
7.00	ROUNDING	6		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)		333,494		0		10.00
11.00	Subtotal (line 3 plus line 10)		8,639,174		0		11.00
12.00	TRANSFERS TO AFFILIATES	1,595,364		0		0	12.00
13.00	OTHER TRANSFERS	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,595,364		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,043,810		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	RESTRICETD NET ASSETS		0				5.00
6.00	TRANSFER TO AFFILIATES		0				6.00
7.00	ROUNDING		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	TRANSFERS TO AFFILIATES		0				12.00
13.00	OTHER TRANSFERS		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: 14-4035

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 12:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	56,957,442		56,957,442	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				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)	56,957,442		56,957,442	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	56,957,442		56,957,442	17.00
18.00	Ancillary services	11,712,176	344,537	12,056,713	18.00
19.00	Outpatient services	0	56,179,721	56,179,721	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ASSESSMENT REVENUE	0	4,880,408	4,880,408	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	68,669,618	61,404,666	130,074,284	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,826,773		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)		61,826,773		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4035

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

Worksheet G-3

Date/Time Prepared:
11/29/2021 12:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	130,074,284	1.00
2.00	Less contractual allowances and discounts on patients' accounts	76,324,685	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,749,599	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,826,773	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,077,174	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	250	6.00
7.00	Income from investments	14,663	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	66,858	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EDUCATION	690,067	24.00
24.01	NORTHWEST COMMUNITY CONTRACT	306,000	24.01
24.02	MILL STREET ADMIN	148,230	24.02
24.03	SEMINARS	17,515	24.03
24.04	RESOURCE/REFERRAL	1,880,310	24.04
24.05	MISCELLANEOUS	70,661	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.50	COVID-19 PHE Funding	2,644,741	24.50
25.00	Total other income (sum of lines 6-24)	5,839,295	25.00
26.00	Total (line 5 plus line 25)	-2,237,879	26.00
27.00	RECONCILING ITEM	8	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	8	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,237,887	29.00