

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: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 11:00 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/28/2022	Time: 11:00 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAKE BEHAVIORAL HOSPITAL (14-4042) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	128,083	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	128,083	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4042		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:00 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2615 WASHINGTON ST			PO Box:				1.00		
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085		County: LAKE 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		LAKE BEHAVIORAL HOSPITAL	144042	29404	4	10/01/2020	N	P	O
4.00	Subprovider - IPF									
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)						10/01/2020	09/30/2021		
21.00	Type of Control (see instructions)						5			
							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				
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 OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 11:00 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 11:00 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					
61.02	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)					
61.03	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)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					
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)					
61.06	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)					
		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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 11:00 am

	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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:00 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	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)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:00 am
		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.	Y	E	93 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	331,247	0	0 118.01
		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.	Y	5.00	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4042		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 11:00 am	
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:	Contractor's Name:		Contractor's Number:					
142.00	Street:	PO Box:							
143.00	City:	State:		Zip Code:					
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?								Y
								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)						0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 11:00 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 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	02/09/2022	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: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 11:00 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	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.		N	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.	WADE	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	WADEH@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/28/2022 11:00 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER		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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 11:00 am

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	146	53,290	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)		146	53,290	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		146	53,290	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	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	116.00	0	0			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)		146			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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 11:00 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,203	1,199	29,104			1.00
2.00	HMO and other (see instructions)	0	14,520				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)	2,203	1,199	29,104			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,203	1,199	29,104	0.00	187.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	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	187.32	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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 11:00 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	169	114	3,062	1.00
2.00 HMO and other (see instructions)			0	1,608		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	169	114	3,062	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	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	0.00					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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 11:00 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		20,853	20,853	0	20,853	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		295,056	295,056	0	295,056	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,056	2,533,371	2,544,427	0	2,544,427	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,306,429	4,372,584	6,679,013	0	6,679,013	5.00
7.00	00700	OPERATION OF PLANT	379,693	907,135	1,286,828	0	1,286,828	7.00
9.00	00900	HOUSEKEEPING	0	439,530	439,530	0	439,530	9.00
10.00	01000	DIETARY	0	678,920	678,920	0	678,920	10.00
13.00	01300	NURSING ADMINISTRATION	724,155	140,453	864,608	0	864,608	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	149,701	22,959	172,660	0	172,660	16.00
17.00	01700	SOCIAL SERVICE	620,135	199,810	819,945	0	819,945	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,274,843	3,097,412	9,372,255	0	9,372,255	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
	ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	233,655	11,668	245,323	0	245,323	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,699,667	12,719,751	23,419,418	0	23,419,418	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,699,667	12,719,751	23,419,418	0	23,419,418	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,863,414	1,884,267	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,738,280	2,033,336	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,544,427	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,772,526	3,906,487	5.00
7.00	00700	OPERATION OF PLANT	0	1,286,828	7.00
9.00	00900	HOUSEKEEPING	0	439,530	9.00
10.00	01000	DIETARY	-4,701	674,219	10.00
13.00	01300	NURSING ADMINISTRATION	0	864,608	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	172,660	16.00
17.00	01700	SOCIAL SERVICE	0	819,945	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,551,142	7,821,113	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	245,323	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-726,675	22,692,743	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-726,675	22,692,743	200.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 11:00 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	878,281	0	0	0	878,281	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	1,028,246	0	0	0	1,028,246	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	219,077	1,267,586	0	1,267,586	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	2,125,604	1,267,586	0	1,267,586	1,906,527	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	2,125,604	1,267,586	0	1,267,586	1,906,527	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					
3.00	Buildings and Fixtures	0	0					
4.00	Building Improvements	0	0					
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	1,486,663	0					
7.00	HIT designated Assets	0	0					
8.00	Subtotal (sum of lines 1-7)	1,486,663	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	1,486,663	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,001	0	0	0	17,852	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	206,201	43,524	986	44,345	0	2.00
3.00	Total (sum of lines 1-2)	209,202	43,524	986	44,345	17,852	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	20,853				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	295,056				2.00
3.00	Total (sum of lines 1-2)	0	315,909				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,486,663	0	1,486,663	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,486,663	0	1,486,663	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	1,866,415	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	226,032	43,524	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,092,447	43,524	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	17,852	0	1,884,267	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,719,435	44,345	0	0	2,033,336	2.00
3.00	Total (sum of lines 1-2)	1,719,435	44,345	17,852	0	3,917,603	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-986	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,551,142			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	3,602,765			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,848	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	REBATES	B	-2,853	DIETARY	10.00	0	33.00

2/28/2022 11:00 am Y:\29465 - Lake Behavioral Hospital\300 - Medicare Cost Report\20210930\HFS\29465-21.mcrx

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	LATE FEES	A	-757	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER MISC INCOME	B	-10,816	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	ADVERTISING	A	-13,368	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING	A	-2,413	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HAF	A	-2,745,257	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-726,675				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: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 11:00 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	LBH REALTY - DEPR	1,863,414	0 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	LBH REALTY - INTEREST	1,719,435	0 2.00
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	LBH REALTY - DEPR	19,831	0 3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	LBH REALTY - A&G	85	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,602,765	0	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	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	G	REALTY CO.	0.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 11:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,863,414	9		1.00
2.00	1,719,435	11		2.00
3.00	19,831	9		3.00
4.00	85	0		4.00
5.00	3,602,765			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: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 11:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	1,551,142	1,551,142	0	0	0	1.00
2.00	0.00		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			1,551,142	1,551,142	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	30.00	DR. A	0	0	0	0	0	1.00
2.00	0.00		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	30.00	DR. A	0	0	0	1,551,142		1.00
2.00	0.00		0	0	0	0		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	1,551,142		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,884,267	1,884,267			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,033,336		2,033,336		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,544,427	5,205	5,617	2,555,249	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,906,487	132,750	143,252	551,382	5.00
7.00	00700	OPERATION OF PLANT	1,286,828	45,881	49,510	90,771	7.00
9.00	00900	HOUSEKEEPING	439,530	18,938	20,436	0	9.00
10.00	01000	DIETARY	674,219	114,597	123,663	0	10.00
13.00	01300	NURSING ADMINISTRATION	864,608	3,217	3,472	173,119	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,660	18,337	19,787	35,788	16.00
17.00	01700	SOCIAL SERVICE	819,945	3,714	4,008	148,251	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,821,113	1,466,608	1,582,636	1,500,080	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	245,323	75,020	80,955	55,858	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,692,743	1,884,267	2,033,336	2,555,249	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,692,743	1,884,267	2,033,336	2,555,249	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	7.00	9.00	10.00	13.00	
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	4,733,871					5.00
7.00	00700	OPERATION OF PLANT	388,273	1,861,263				7.00
9.00	00900	HOUSEKEEPING	126,237	20,729	625,870			9.00
10.00	01000	DIETARY	240,525	125,436	42,654	1,321,094		10.00
13.00	01300	NURSING ADMINISTRATION	275,303	3,522	1,198	0	1,324,439	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,995	20,071	6,825	0	0	16.00
17.00	01700	SOCIAL SERVICE	257,247	4,066	1,383	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,260,787	1,605,323	545,887	1,321,094	1,324,439	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	120,504	82,116	27,923	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,733,871	1,861,263	625,870	1,321,094	1,324,439	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,733,871	1,861,263	625,870	1,321,094	1,324,439	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	338,463					16.00
17.00	01700	SOCIAL SERVICE	0	1,238,614				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	325,780	1,238,614	21,992,361	0	21,992,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12,683	0	700,382	0	700,382	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338,463	1,238,614	22,692,743	0	22,692,743	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	338,463	1,238,614	22,692,743	0	22,692,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,205	5,617	10,822	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	132,750	143,252	276,002	5.00
7.00	00700	OPERATION OF PLANT	0	45,881	49,510	95,391	7.00
9.00	00900	HOUSEKEEPING	0	18,938	20,436	39,374	9.00
10.00	01000	DIETARY	0	114,597	123,663	238,260	10.00
13.00	01300	NURSING ADMINISTRATION	0	3,217	3,472	6,689	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,337	19,787	38,124	16.00
17.00	01700	SOCIAL SERVICE	0	3,714	4,008	7,722	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,466,608	1,582,636	3,049,244	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	75,020	80,955	155,975	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,884,267	2,033,336	3,917,603	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,884,267	2,033,336	3,917,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	7.00	9.00	10.00	13.00	
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	278,336					5.00
7.00	00700	OPERATION OF PLANT	22,830	118,605				7.00
9.00	00900	HOUSEKEEPING	7,423	1,321	48,118			9.00
10.00	01000	DIETARY	14,143	7,993	3,279	263,675		10.00
13.00	01300	NURSING ADMINISTRATION	16,187	224	92	0	23,925	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,822	1,279	525	0	0	16.00
17.00	01700	SOCIAL SERVICE	15,126	259	106	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	191,720	102,296	41,969	263,675	23,925	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,085	5,233	2,147	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	278,336	118,605	48,118	263,675	23,925	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	278,336	118,605	48,118	263,675	23,925	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,901					16.00
17.00	01700	SOCIAL SERVICE	0	23,841				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,257	23,841	3,745,283	0	3,745,283	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,644	0	172,320	0	172,320	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,901	23,841	3,917,603	0	3,917,603	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,901	23,841	3,917,603	0	3,917,603	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,035				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		72,035			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	199	199	10,688,611		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,075	5,075	2,306,429	-4,733,871	5.00
7.00	00700	OPERATION OF PLANT	1,754	1,754	379,693	0	7.00
9.00	00900	HOUSEKEEPING	724	724	0	0	9.00
10.00	01000	DIETARY	4,381	4,381	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	123	123	724,155	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	701	701	149,701	0	16.00
17.00	01700	SOCIAL SERVICE	142	142	620,135	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,068	56,068	6,274,843	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,868	2,868	233,655	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,035	72,035	10,688,611	-4,733,871	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,884,267	2,033,336	2,555,249	4,733,871	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.157659	28.227056	0.239063	0.263595	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,822	278,336	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001012	0.015499	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			7.00	9.00	10.00	13.00	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	65,007					7.00
9.00	00900	HOUSEKEEPING	724	64,283				9.00
10.00	01000	DIETARY	4,381	4,381	87,312			10.00
13.00	01300	NURSING ADMINISTRATION	123	123	0	216,634		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	701	701	0	0	64,516,974	16.00
17.00	01700	SOCIAL SERVICE	142	142	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,068	56,068	87,312	216,634	62,099,320	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,868	2,868	0	0	2,417,654	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,007	64,283	87,312	216,634	64,516,974	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,861,263	625,870	1,321,094	1,324,439	338,463	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.631732	9.736167	15.130727	6.113717	0.005246	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	118,605	48,118	263,675	23,925	43,901	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.824496	0.748534	3.019917	0.110440	0.000680	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		SOCIAL SERVICE	
		(TOTAL PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		29,104	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
ANCILLARY SERVICE COST CENTERS			
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		29,104	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		1,238,614	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		23,841	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.819166	
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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 11:00 am

			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	21,992,361		21,992,361	0	21,992,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	0		0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	700,382		700,382	0	700,382	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	22,692,743	0	22,692,743	0	22,692,743	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	22,692,743	0	22,692,743	0	22,692,743	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 11:00 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
9.00			10.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	62,099,320		62,099,320			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
	ANCILLARY SERVICE COST CENTERS							
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,417,654	2,417,654	0.289695	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	62,099,320	2,417,654	64,516,974			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,099,320	2,417,654	64,516,974			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.289695			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 11:00 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,992,361		21,992,361	0	21,992,361	
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0		0	0	0	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	
56.00	05600	RADIOISOTOPE	0		0	0	0	
57.00	05700	CT SCAN	0		0	0	0	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	
60.00	06000	LABORATORY	0		0	0	0	
60.01	06001	BLOOD LABORATORY	0		0	0	0	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	
74.00	07400	RENAL DIALYSIS	0		0	0	0	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	700,382		700,382	0	700,382	
91.00	09100	EMERGENCY	0		0	0	0	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	0		0	0	0	
200.00		Subtotal (see instructions)	22,692,743	0	22,692,743	0	22,692,743	
201.00		Less Observation Beds	0		0	0	0	
202.00		Total (see instructions)	22,692,743	0	22,692,743	0	22,692,743	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 11:00 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,099,320		62,099,320		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
	ANCILLARY SERVICE COST CENTERS						
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,417,654	2,417,654	0.289695	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	62,099,320	2,417,654	64,516,974		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	62,099,320	2,417,654	64,516,974		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 11:00 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,745,283	0	3,745,283	29,104	128.69	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
200.00	Total (lines 30 through 199)	3,745,283		3,745,283	29,104		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	2,203	283,504				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
200.00	Total (lines 30 through 199)	2,203	283,504				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 11:00 am

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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	0	0	0.000000	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	172,320	2,417,654	0.071276	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	172,320	2,417,654		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part III
Date/Time Prepared:
2/28/2022 11:00 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	29,104	0.00	2,203	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
200.00		Total (lines 30 through 199)		0	29,104		2,203	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						
40.00	04000	SUBPROVIDER - IPF	0						
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 11:00 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,417,654	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	2,417,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 14-4042 Period: From 10/01/2020 To 09/30/2021 Worksheet D Part IV Date/Time Prepared: 2/28/2022 11:00 am

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	87,835	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (lines 50 through 199)		0	0	87,835	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-4042		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 2/28/2022 11:00 am		
				Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
			1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS									
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.289695	87,835	0	0	0	25,445	90.00	
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0				95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	0	98.00	
200.00		Subtotal (see instructions)		87,835	0	0	0	25,445	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00	
202.00		Net Charges (line 200 - line 201)		87,835	0	0	0	25,445	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 11:00 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 11:00 am

		Title XIX		Hospital		Cost	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	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							
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.289695	0	43,518	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)		0	43,518	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		0	43,518	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 11:00 am

			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,607	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	12,607	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	12,607	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:00 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		29,104	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		29,104	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		29,104	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,203	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)		21,992,361	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)		21,992,361	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)		21,992,361	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)		755.65	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,664,697	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,664,697	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:00 am	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,548,168	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)					283,504	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)					283,504	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,264,664	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: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 11:00 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,745,283	21,992,361	0.170299	0	0 90.00
91.00	Nursing Program cost	0	21,992,361	0.000000	0	0 91.00
92.00	Allied health cost	0	21,992,361	0.000000	0	0 92.00
93.00	All other Medical Education	0	21,992,361	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:00 am	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		29,104	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		29,104	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		29,104	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,199	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)		21,992,361	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)		21,992,361	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)		21,992,361	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)		755.65	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		906,024	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)		906,024	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 11:00 am	
			Title XIX	Hospital	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					842,602	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: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 11:00 am

		Title XIX		Hospital	Cost	
Cost Center Description		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	3,745,283	21,992,361	0.170299	0	0 90.00
91.00	Nursing Program cost	0	21,992,361	0.000000	0	0 91.00
92.00	Allied health cost	0	21,992,361	0.000000	0	0 92.00
93.00	All other Medical Education	0	21,992,361	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 11:00 am
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		4,686,510	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.289695	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

Health Financial Systems		LAKE BEHAVIORAL HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 11:00 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,873,934	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.289695	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 11:00 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		25,445	2.00
3.00	OPPS payments		36,521	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	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)		36,521	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)		7,306	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)		29,215	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)		29,215	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		29,215	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		29,215	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)		29,215	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		29,215	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)		0	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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 11:00 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,726,663		29,215	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)		1,726,663		29,215	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		128,083		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,854,746		29,215	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: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet E-3
Part II
Date/Time Prepared:
2/28/2022 11:00 am

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)	1,926,882	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	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 instructions)	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 instructions)	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)	79.736986	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)	1,926,882	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)	1,926,882	16.00
17.00	Primary payer payments	13,222	17.00
18.00	Subtotal (line 16 less line 17).	1,913,660	18.00
19.00	Deductibles	150,800	19.00
20.00	Subtotal (line 18 minus line 19)	1,762,860	20.00
21.00	Coinurance	36,197	21.00
22.00	Subtotal (line 20 minus line 21)	1,726,663	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	197,050	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	128,083	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	113,654	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,854,746	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
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,854,746	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	1,726,663	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)	128,083	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	0	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: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2022 11:00 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	842,602			1.00
2.00	Medical and other services			12,607	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	842,602		12,607	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)	842,602		12,607	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	1,873,934			8.00
9.00	Ancillary service charges	0		43,518	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,873,934		43,518	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	1,873,934		43,518	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,031,332		30,911	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	842,602		12,607	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)	842,602		12,607	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	842,602		12,607	31.00
32.00	Deductibles	0			32.00
33.00	Coinurance	0			33.00
34.00	Allowable bad debts (see instructions)	0			34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	842,602		12,607	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0			37.00
38.00	Subtotal (line 36 ± line 37)	842,602		12,607	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)	842,602		12,607	40.00
41.00	Interim payments	842,602		12,607	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		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: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/28/2022 11:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	509,025	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	4,922,307	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,947,452	0	0	0	6.00
7.00	Inventory	70,087	0	0	0	7.00
8.00	Prepaid expenses	327,064	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)	3,881,031	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	1,486,663	0	0	0	23.00
24.00	Accumulated depreciation	-414,413	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,072,250	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	16,356,987	0	0	0	33.00
34.00	Other assets	144,353	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,501,340	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,454,621	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,655,583	0	0	0	37.00
38.00	Salaries, wages, and fees payable	530,810	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	328,370	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,514,763	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,580,819	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,580,819	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,095,582	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,359,039	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)	17,359,039	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,454,621	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/28/2022 11:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,251,509		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,120,046				2.00
3.00	Total (sum of line 1 and line 2)		17,371,555		0		3.00
4.00	OTHER ADDITIONS	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,371,555		0		11.00
12.00	OTHER DEDUCTIONS	12,516		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		12,516		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,359,039		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	OTHER ADDITIONS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	OTHER DEDUCTIONS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-4042

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 11:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	62,099,320		62,099,320	1.00
2.00	SUBPROVIDER - IPF	0		0	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)	62,099,320		62,099,320	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	62,099,320		62,099,320	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	2,417,654	2,417,654	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	4,826,879	0	4,826,879	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	66,926,199	2,417,654	69,343,853	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,419,418		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)		23,419,418		43.00

Health Financial Systems		LAKE BEHAVIORAL HOSPITAL		In Lieu of Form CMS-2552-10	
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-4042	Period: From 10/01/2020 To 09/30/2021	Worksheet G-3 Date/Time Prepared: 2/28/2022 11:00 am	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			69,343,853	1.00
2.00	Less contractual allowances and discounts on patients' accounts			45,279,637	2.00
3.00	Net patient revenues (line 1 minus line 2)			24,064,216	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			23,419,418	4.00
5.00	Net income from service to patients (line 3 minus line 4)			644,798	5.00
OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			7,999	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			2,853	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			1,848	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	BAD DEBT			-534,691	24.00
24.01	OTHER (SPECIFY)			0	24.01
24.02	OTHER (SPECIFY)			0	24.02
24.03	OTHER MISC			10,816	24.03
24.04	OTHER (SPECIFY)			0	24.04
24.05	HFS ASSESSMENT FEE			3,986,423	24.05
24.06	OTHER (SPECIFY)			0	24.06
24.07	OTHER (SPECIFY)			0	24.07
24.08	OTHER (SPECIFY)			0	24.08
24.50	COVID-19 PHE Funding			0	24.50
25.00	Total other income (sum of lines 6-24)			3,475,248	25.00
26.00	Total (line 5 plus line 25)			4,120,046	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			4,120,046	29.00