

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: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 3/26/2021 8:04 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (14-1322) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KATHRYN KEIM
 Officer or Administrator of Provider(s)

SENIOR VICE PRESIDENT & CFO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-306,461	632,931	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	-228,438	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-534,899	632,931	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: 14-1322		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:04 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 200 STAHLHUT DRIVE			PO Box:				1.00	
2.00	City: LINCOLN			State: IL		Zip Code: 62656		County: LOGAN	
		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			ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N O N
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N O N
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)						10/01/2019	09/30/2020	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1322

Period:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	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.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:04 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.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	38,294	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1322		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:04 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: MEMORIAL HELATH SYSTEM	Contractor's Name: NGS		Contractor's Number: 00131						
142.00	Street: 701 NORTH FIRST STREET	PO Box:								
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62781						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N		149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		
156.00	Subprovider - IPF	N		N		N		N		
157.00	Subprovider - IRF	N		N		N		N		
158.00	SUBPROVIDER									
159.00	SNF	N		N		N		N		
160.00	HOME HEALTH AGENCY	N		N		N		N		
161.00	CMHC			N		N		N		
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00		169.00	
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 8:04 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/22/2021	Y	03/22/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 8:04 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?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
3/26/2021 8:04 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.	DIRECTOR	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: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 8:04 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	25	9,150	66,706.00	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)		25	9,150	66,706.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	66,706.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 8:04 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)	1,484	48	2,657			1.00
2.00	HMO and other (see instructions)	13	0				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	1,432	0	1,702			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	156			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,916	48	4,515			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		40	249			13.00
14.00	Total (see instructions)	2,916	88	4,764	0.00	272.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	272.20	27.00
28.00	Observation Bed Days		8	363			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			49			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	68			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: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 8:04 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	368	19	763	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	368	19	763	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet S-10

Date/Time Prepared:
3/26/2021 8:04 am

			3/26/2021 8:04 am	
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.289401	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,612,420	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		25,786,058	6.00
7.00	Medicaid cost (line 1 times line 6)		7,462,511	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		2,850,091	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		27,610	9.00
10.00	Stand-alone CHIP charges		121,029	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		35,026	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		7,416	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,857,507	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	607,870	195,200	803,070
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	175,918	195,200	371,118
22.00	Payments received from patients for amounts previously written off as charity care	4,661	0	4,661
23.00	Cost of charity care (line 21 minus line 22)	171,257	195,200	366,457
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,132,665		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	424,830		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	653,585		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,479,080		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,235,604		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,602,061		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,459,568		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
3/26/2021 8:04 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		2,661,640	2,661,640	16,703	2,678,343	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,137,956	1,137,956	5,901	1,143,857	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	470,592	4,858,471	5,329,063	-132,670	5,196,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,311,163	5,171,771	7,482,934	-22,604	7,460,330	5.00
7.00	00700	OPERATION OF PLANT	626,820	807,901	1,434,721	0	1,434,721	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	230,311	230,311	8.00
9.00	00900	HOUSEKEEPING	410,874	270,353	681,227	-230,311	450,916	9.00
10.00	01000	DIETARY	644,959	379,336	1,024,295	-497,704	526,591	10.00
11.00	01100	CAFETERIA	0	0	0	480,955	480,955	11.00
13.00	01300	NURSING ADMINISTRATION	505,651	66,918	572,569	-256,969	315,600	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	216,197	190,877	407,074	-114,961	292,113	14.00
15.00	01500	PHARMACY	479,134	1,486,916	1,966,050	-1,475,913	490,137	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	535,178	54,930	590,108	0	590,108	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	251,923	251,923	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	982,991	0	982,991	132,670	1,115,661	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,943,817	1,582,069	3,525,886	642,529	4,168,415	30.00
43.00	04300	NURSERY	0	0	0	125,376	125,376	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	890,767	580,866	1,471,633	-77,540	1,394,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	729,207	279,254	1,008,461	-767,936	240,525	52.00
53.00	05300	ANESTHESIOLOGY	0	195,758	195,758	-491	195,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,533,673	662,759	2,196,432	-21,206	2,175,226	54.00
60.00	06000	LABORATORY	953,297	1,355,593	2,308,890	0	2,308,890	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	461,912	32,128	494,040	0	494,040	65.00
66.00	06600	PHYSICAL THERAPY	1,367,883	63,670	1,431,553	0	1,431,553	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,386	611	170,997	0	170,997	67.00
68.00	06800	SPEECH PATHOLOGY	74,008	196	74,204	0	74,204	68.00
69.00	06900	ELECTROCARDIOLOGY	211,074	116,772	327,846	0	327,846	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	115,549	115,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,117	77,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,504,082	1,504,082	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	205,434	95,356	300,790	0	300,790	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	15,211	15,211	76.01
76.97	07697	CARDIAC REHABILITATION	162,869	13,196	176,065	0	176,065	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,584,496	3,323,185	4,907,681	-22	4,907,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,472,382	25,388,482	42,860,864	0	42,860,864	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
200.00		TOTAL (SUM OF LINES 118 through 199)	17,472,382	25,388,482	42,860,864	0	42,860,864	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
3/26/2021 8:04 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	62,549	2,740,892	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	83,409	1,227,266	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-12,145	5,184,248	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,021,425	6,438,905	5.00
7.00	00700	OPERATION OF PLANT	0	1,434,721	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	230,311	8.00
9.00	00900	HOUSEKEEPING	0	450,916	9.00
10.00	01000	DIETARY	0	526,591	10.00
11.00	01100	CAFETERIA	-132,483	348,472	11.00
13.00	01300	NURSING ADMINISTRATION	0	315,600	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	292,113	14.00
15.00	01500	PHARMACY	0	490,137	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-961	589,147	16.00
17.00	01700	SOCIAL SERVICE	0	251,923	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,115,661	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,100,681	3,067,734	30.00
43.00	04300	NURSERY	0	125,376	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-73,114	1,320,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-99,058	141,467	52.00
53.00	05300	ANESTHESIOLOGY	-173,068	22,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,175,226	54.00
60.00	06000	LABORATORY	-3,387	2,305,503	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	494,040	65.00
66.00	06600	PHYSICAL THERAPY	-53,777	1,377,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	170,997	67.00
68.00	06800	SPEECH PATHOLOGY	-1,188	73,016	68.00
69.00	06900	ELECTROCARDIOLOGY	-93,578	234,268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	115,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	77,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,504,082	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	300,790	76.00
76.01	03950	DIABETIC EDUCATION	0	15,211	76.01
76.97	07697	CARDIAC REHABILITATION	0	176,065	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,570,555	2,337,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,305,123	36,555,741	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
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,305,123	36,555,741	200.00

RECLASSIFICATIONS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
3/26/2021 8:04 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	515,238	127,322	1.00
2.00	NURSERY	43.00	100,533	24,843	2.00
			615,771	152,165	
	C - CASE MANAGEMENT				
1.00	SOCIAL SERVICE	17.00	251,923	0	1.00
			251,923	0	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	22,604	1.00
			0	22,604	
	E - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,504,082	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
			0	1,504,082	
	F - LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	36,912	193,399	1.00
			36,912	193,399	
	G - IMPLANTS & MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	115,549	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	77,117	2.00
3.00		0.00	0	0	3.00
			0	192,666	
	H - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	300,612	180,343	1.00
2.00	DIABETIC EDUCATION	76.01	15,211	0	2.00
			315,823	180,343	
	K - CRNA BENEFITS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	132,670	1.00
			0	132,670	
500.00	Grand Total: Increases		1,220,429	2,377,929	500.00

RECLASSIFICATIONS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
3/26/2021 8:04 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	615,771	152,165	0	1.00	
2.00		0.00	0	0	0	2.00	
	0		615,771	152,165			
	C - CASE MANAGEMENT						
1.00	NURSING ADMINISTRATION	13.00	251,923	0	0	1.00	
	0		251,923	0			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,604	12	1.00	
	0		0	22,604			
	E - DRUG EXPENSE						
1.00	DIETARY	10.00	0	1,538	0	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	5,046	0	2.00	
3.00	PHARMACY	15.00	0	1,475,748	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	31	0	4.00	
5.00	ANESTHESIOLOGY	53.00	0	491	0	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,206	0	6.00	
7.00	EMERGENCY	91.00	0	22	0	7.00	
	0		0	1,504,082			
	F - LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	36,912	193,399	0	1.00	
	0		36,912	193,399			
	G - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	114,961	0	1.00	
2.00	PHARMACY	15.00	0	165	0	2.00	
3.00	OPERATING ROOM	50.00	0	77,540	0	3.00	
	0		0	192,666			
	H - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	315,823	180,343	0	1.00	
2.00		0.00	0	0	0	2.00	
	0		315,823	180,343			
	K - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	132,670	0	1.00	
	0		0	132,670			
500.00	Grand Total: Decreases		1,220,429	2,377,929		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
3/26/2021 8:04 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	1,454,817	0	0	0	33,601	1.00	
2.00	Land Improvements	6,078,200	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	42,874,213	1,998,659	0	1,998,659	222,642	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	16,111,948	880,889	0	880,889	1,500	6.00	
7.00	HIT designated Assets	1,433,236	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	67,952,414	2,879,548	0	2,879,548	257,743	8.00	
9.00	Reconciling Items	-1,966,594	0	0	0	-1,719,499	9.00	
10.00	Total (line 8 minus line 9)	69,919,008	2,879,548	0	2,879,548	1,977,242	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,421,216	0				1.00	
2.00	Land Improvements	6,078,200	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	44,650,230	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	16,991,337	0				6.00	
7.00	HIT designated Assets	1,433,236	0				7.00	
8.00	Subtotal (sum of lines 1-7)	70,574,219	0				8.00	
9.00	Reconciling Items	-247,095	0				9.00	
10.00	Total (line 8 minus line 9)	70,821,314	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
3/26/2021 8:04 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	2,661,640	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,137,956	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,799,596	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,661,640				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,137,956				2.00
3.00	Total (sum of lines 1-2)	0	3,799,596				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
3/26/2021 8:04 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	52,149,646	0	52,149,646	0.738933	16,703	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,424,573	0	18,424,573	0.261067	5,901	2.00
3.00	Total (sum of lines 1-2)	70,574,219	0	70,574,219	1.000000	22,604	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	16,703	2,724,189	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,901	1,221,365	0	2.00
3.00	Total (sum of lines 1-2)	0	0	22,604	3,945,554	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	16,703	0	0	2,740,892	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,901	0	0	1,227,266	2.00
3.00	Total (sum of lines 1-2)	0	22,604	0	0	3,968,158	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
3/26/2021 8:04 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-10,049	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-734	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,634	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-14,394	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,110,054			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	739,538			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-132,483	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-961	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,115,661	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	A	-45,468	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INCOME - A&G	B	-1,159	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
3/26/2021 8:04 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	RENTAL INCOME	B	-3,405	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INCOME - LAB	B	-3,387	LABORATORY	60.00	0	33.02
33.03	MISC INCOME - PT	B	-53,777	PHYSICAL THERAPY	66.00	0	33.03
33.04	MISC INCOME - ST	B	-1,188	SPEECH PATHOLOGY	68.00	0	33.04
34.00	PROVIDER TAX	A	-1,567,003	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	IL RETAILERS TAX (REVERSE CREDIT)	A	66	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	MARKETING - SALARIES	A	-52,092	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	MARKETING - BENEFITS	A	-12,145	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.02
35.03	MARKETING - OTHER	A	-61,680	ADMINISTRATIVE & GENERAL	5.00	0	35.03
36.00	FUNDED DEPRECIATION TRUSTEE FEES	A	14,840	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MUTUAL FUND FEES	A	159,124	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	LOBBYING EXPENSE	A	-19,670	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	PHYSICIAN LOAN FORGIVENESS	A	-9,747	ADMINISTRATIVE & GENERAL	5.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,305,123				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: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
3/26/2021 8:04 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	HO NEW CAPITAL - BLDG	46,519	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	3,125	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	16,030	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	125,752	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	10,049	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,244,202	1,525,074	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	2,482,352	2,663,417	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	324,408	324,408	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,252,437	4,512,899	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	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	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: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
3/26/2021 8:04 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	46,519	9		1.00
2.00	3,125	9		2.00
3.00	16,030	9		3.00
4.00	125,752	9		4.00
4.01	10,049	0		4.01
4.02	719,128	0		4.02
4.03	-181,065	0		4.03
4.04	0	0		4.04
5.00	739,538			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	MANAGEMENT/HO		6.00
7.00	HOSPITAL		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: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
3/26/2021 8:04 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	ADULTS & PEDIATRICS	1,100,681	1,100,681	0	0	0	1.00
2.00	50.00	OPERATING ROOM	73,114	73,114	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	99,058	99,058	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	173,068	173,068	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	93,578	93,578	0	0	0	5.00
6.00	91.00	EMERGENCY	2,826,576	2,570,555	256,021	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			4,366,075	4,110,054	256,021		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	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	ADULTS & PEDIATRICS	0	0	0	1,100,681		1.00
2.00	50.00	OPERATING ROOM	0	0	0	73,114		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	99,058		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	173,068		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	93,578		5.00
6.00	91.00	EMERGENCY	0	0	0	2,570,555		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	4,110,054		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,740,892	2,740,892				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,227,266		1,227,266			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,184,248	2,499	0	5,186,747		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,438,905	167,416	288,589	733,855	7,628,765	5.00
7.00	00700	OPERATION OF PLANT	1,434,721	959,298	42,695	203,621	2,640,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	230,311	12,239	0	11,991	254,541	8.00
9.00	00900	HOUSEKEEPING	450,916	68,457	211	121,481	641,065	9.00
10.00	01000	DIETARY	526,591	51,989	33,647	106,919	719,146	10.00
11.00	01100	CAFETERIA	348,472	52,416	30,732	97,653	529,273	11.00
13.00	01300	NURSING ADMINISTRATION	315,600	7,946	42	82,423	406,011	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	292,113	50,472	0	70,231	412,816	14.00
15.00	01500	PHARMACY	490,137	30,501	10,575	155,646	686,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589,147	36,995	202	173,852	800,196	16.00
17.00	01700	SOCIAL SERVICE	251,923	0	0	81,837	333,760	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,067,734	390,708	61,664	798,811	4,318,917	30.00
43.00	04300	NURSERY	125,376	7,946	6,358	32,658	172,338	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,320,979	223,783	245,272	289,364	2,079,398	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,467	13,948	7,174	36,850	199,439	52.00
53.00	05300	ANESTHESIOLOGY	22,199	6,493	7,658	0	36,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,175,226	160,324	292,506	498,211	3,126,267	54.00
60.00	06000	LABORATORY	2,305,503	96,310	70,436	309,677	2,781,926	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	494,040	19,309	10,748	150,051	674,148	65.00
66.00	06600	PHYSICAL THERAPY	1,377,776	108,335	19,061	444,354	1,949,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,997	0	0	55,350	226,347	67.00
68.00	06800	SPEECH PATHOLOGY	73,016	2,307	0	24,041	99,364	68.00
69.00	06900	ELECTROCARDIOLOGY	234,268	3,823	42,006	68,567	348,664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,549	0	0	0	115,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,117	0	0	0	77,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,504,082	0	0	0	1,504,082	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	300,790	35,905	0	66,735	403,430	76.00
76.01	03950	DIABETIC EDUCATION	15,211	0	0	4,941	20,152	76.01
76.97	07697	CARDIAC REHABILITATION	176,065	83,622	16,646	52,908	329,241	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,337,104	128,093	41,044	514,720	3,020,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,555,741	2,721,134	1,227,266	5,186,747	36,535,983	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,758	0	0	19,758	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,555,741	2,740,892	1,227,266	5,186,747	36,555,741	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,628,765					5.00
7.00	00700	OPERATION OF PLANT	696,322	3,336,657				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,129	25,338	347,008			8.00
9.00	00900	HOUSEKEEPING	169,065	141,727	0	951,857		9.00
10.00	01000	DIETARY	189,657	107,633	877	32,323	1,049,636	10.00
11.00	01100	CAFETERIA	139,583	108,517	801	32,589	0	11.00
13.00	01300	NURSING ADMINISTRATION	107,075	16,450	0	4,940	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,870	104,493	0	31,380	0	14.00
15.00	01500	PHARMACY	181,142	63,147	0	18,964	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	211,032	76,590	0	23,001	0	16.00
17.00	01700	SOCIAL SERVICE	88,021	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,139,003	808,882	110,606	242,914	1,032,957	30.00
43.00	04300	NURSERY	45,450	16,450	2,277	4,940	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	548,389	463,298	35,713	139,133	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,597	28,876	2,570	8,672	0	52.00
53.00	05300	ANESTHESIOLOGY	9,586	13,443	0	4,037	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	824,475	331,919	45,955	99,678	0	54.00
60.00	06000	LABORATORY	733,663	199,390	24	59,879	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	177,790	39,975	0	12,005	0	65.00
66.00	06600	PHYSICAL THERAPY	514,139	224,286	40,525	67,355	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,693	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,205	4,776	0	1,434	0	68.00
69.00	06900	ELECTROCARDIOLOGY	91,951	7,915	8,902	2,377	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,473	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,338	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396,664	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	106,395	74,335	0	22,323	0	76.00
76.01	03950	DIABETIC EDUCATION	5,315	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	86,829	173,123	0	51,990	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	796,703	265,190	89,851	79,639	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,623,554	3,295,753	338,101	939,573	1,032,957	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,211	40,904	0	12,284	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,907	0	16,679	192.00
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)	7,628,765	3,336,657	347,008	951,857	1,049,636	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	810,763					11.00
13.00	01300	NURSING ADMINISTRATION	12,426	546,902				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,240	0	678,799			14.00
15.00	01500	PHARMACY	23,264	0	1,507	974,883		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,459	0	34	0	1,161,312	16.00
17.00	01700	SOCIAL SERVICE	12,347	18,426	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	176,905	254,500	66,692	0	158,241	30.00
43.00	04300	NURSERY	5,677	6,458	617	0	19,634	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	57,288	85,768	89,187	0	142,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,392	7,286	696	0	5,861	52.00
53.00	05300	ANESTHESIOLOGY	14,927	22,344	6,494	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,755	0	35,450	0	94,651	54.00
60.00	06000	LABORATORY	81,307	0	309,674	0	87,326	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	30,291	0	6,353	0	16,996	65.00
66.00	06600	PHYSICAL THERAPY	78,647	0	8,823	0	11,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,655	0	226	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,414	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,982	0	2,339	0	17,875	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	45,483	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	30,355	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	974,883	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12,387	0	33	0	7,326	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	2,930	76.01
76.97	07697	CARDIAC REHABILITATION	9,806	0	925	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	101,594	152,120	73,911	0	593,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	810,763	546,902	678,799	974,883	1,158,382	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	2,930	192.00
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)	810,763	546,902	678,799	974,883	1,161,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	452,554					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	452,554	0	8,762,171	-588,443	8,173,728	30.00
43.00	04300	NURSERY	0	0	273,841	0	273,841	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	3,640,591	0	3,640,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	312,389	0	312,389	52.00
53.00	05300	ANESTHESIOLOGY	0	0	107,181	0	107,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,649,150	0	4,649,150	54.00
60.00	06000	LABORATORY	0	0	4,253,189	0	4,253,189	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	588,443	588,443	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	957,558	0	957,558	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,894,436	0	2,894,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	294,921	0	294,921	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	135,193	0	135,193	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	493,005	0	493,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	191,505	0	191,505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	127,810	0	127,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,875,629	0	2,875,629	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	626,229	0	626,229	76.00
76.01	03950	DIABETIC EDUCATION	0	0	28,397	0	28,397	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	651,914	0	651,914	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	5,173,959	0	5,173,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	452,554	0	36,449,068	0	36,449,068	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	78,157	0	78,157	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	28,516	0	28,516	192.00
200.00		Cross Foot Adjustments			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)	452,554	0	36,555,741	0	36,555,741	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,499	0	2,499	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,350	167,416	288,589	474,355	5.00
7.00	00700	OPERATION OF PLANT	11,101	959,298	42,695	1,013,094	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,239	0	12,239	8.00
9.00	00900	HOUSEKEEPING	0	68,457	211	68,668	9.00
10.00	01000	DIETARY	0	51,989	33,647	85,636	10.00
11.00	01100	CAFETERIA	0	52,416	30,732	83,148	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,946	42	7,988	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	50,472	0	50,472	14.00
15.00	01500	PHARMACY	0	30,501	10,575	41,076	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,995	202	37,197	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,230	390,708	61,664	470,602	30.00
43.00	04300	NURSERY	0	7,946	6,358	14,304	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,500	223,783	245,272	470,555	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,948	7,174	21,122	52.00
53.00	05300	ANESTHESIOLOGY	0	6,493	7,658	14,151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109	160,324	292,506	452,939	54.00
60.00	06000	LABORATORY	44	96,310	70,436	166,790	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	196	19,309	10,748	30,253	65.00
66.00	06600	PHYSICAL THERAPY	30	108,335	19,061	127,426	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,307	0	2,307	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,823	42,006	45,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	35,905	0	35,905	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	83,622	16,646	100,268	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	128,093	41,044	169,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,560	2,721,134	1,227,266	3,997,960	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,758	0	19,758	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,560	2,740,892	1,227,266	4,017,718	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	474,710					5.00
7.00	00700	OPERATION OF PLANT	43,331	1,056,523				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,177	8,023	24,445			8.00
9.00	00900	HOUSEKEEPING	10,521	44,876	0	124,124		9.00
10.00	01000	DIETARY	11,802	34,081	62	4,215	135,848	10.00
11.00	01100	CAFETERIA	8,686	34,361	56	4,250	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,663	5,209	0	644	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,775	33,087	0	4,092	0	14.00
15.00	01500	PHARMACY	11,272	19,995	0	2,473	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,132	24,252	0	2,999	0	16.00
17.00	01700	SOCIAL SERVICE	5,477	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,866	256,126	7,792	31,678	133,689	30.00
43.00	04300	NURSERY	2,828	5,209	160	644	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,125	146,699	2,516	18,143	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,273	9,143	181	1,131	0	52.00
53.00	05300	ANESTHESIOLOGY	597	4,257	0	526	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,305	105,099	3,237	12,998	0	54.00
60.00	06000	LABORATORY	45,654	63,135	2	7,808	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,063	12,658	0	1,565	0	65.00
66.00	06600	PHYSICAL THERAPY	31,994	71,018	2,855	8,783	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,715	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,631	1,512	0	187	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,722	2,506	627	310	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,266	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,683	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,621	23,537	0	2,911	0	76.00
76.01	03950	DIABETIC EDUCATION	331	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	5,403	54,818	0	6,780	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	49,577	83,970	6,330	10,385	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	474,386	1,043,571	23,818	122,522	133,689	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	324	12,952	0	1,602	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	627	0	2,159	192.00
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)	474,710	1,056,523	24,445	124,124	135,848	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	130,548					11.00
13.00	01300	NURSING ADMINISTRATION	2,001	22,545				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	0	97,880			14.00
15.00	01500	PHARMACY	3,746	0	217	78,854		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,125	0	5	0	85,794	16.00
17.00	01700	SOCIAL SERVICE	1,988	760	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,486	10,491	9,617	0	11,690	30.00
43.00	04300	NURSERY	914	266	89	0	1,450	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,224	3,536	12,860	0	10,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,029	300	100	0	433	52.00
53.00	05300	ANESTHESIOLOGY	2,404	921	936	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,613	0	5,112	0	6,993	54.00
60.00	06000	LABORATORY	13,092	0	44,655	0	6,451	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,877	0	916	0	1,256	65.00
66.00	06600	PHYSICAL THERAPY	12,664	0	1,272	0	823	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,394	0	33	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	550	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,090	0	337	0	1,321	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,558	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,377	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	78,854	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,994	0	5	0	541	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	216	76.01
76.97	07697	CARDIAC REHABILITATION	1,579	0	133	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	16,358	6,271	10,658	0	43,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,548	22,545	97,880	78,854	85,578	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	216	192.00
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)	130,548	22,545	97,880	78,854	85,794	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	8,265					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,265		1,039,677	0	1,039,677	30.00
43.00	04300	NURSERY	0		25,880	0	25,880	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		708,319	0	708,319	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		36,730	0	36,730	52.00
53.00	05300	ANESTHESIOLOGY	0		23,792	0	23,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		652,537	0	652,537	54.00
60.00	06000	LABORATORY	0		347,737	0	347,737	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		62,661	0	62,661	65.00
66.00	06600	PHYSICAL THERAPY	0		257,050	0	257,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		5,169	0	5,169	67.00
68.00	06800	SPEECH PATHOLOGY	0		6,199	0	6,199	68.00
69.00	06900	ELECTROCARDIOLOGY	0		58,775	0	58,775	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		8,454	0	8,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		5,643	0	5,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		103,537	0	103,537	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		71,546	0	71,546	76.00
76.01	03950	DIABETIC EDUCATION	0		549	0	549	76.01
76.97	07697	CARDIAC REHABILITATION	0		169,007	0	169,007	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0		396,818	0	396,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,265	0	3,980,080	0	3,980,080	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		34,636	0	34,636	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		3,002	0	3,002	192.00
200.00		Cross Foot Adjustments		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)	8,265	0	4,017,718	0	4,017,718	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	128,322					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,221,365				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	15,966,708			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,838	287,202	2,259,071	-7,628,765	28,926,976	5.00
7.00	00700	OPERATION OF PLANT	44,912	42,490	626,820	0	2,640,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	36,912	0	254,541	8.00
9.00	00900	HOUSEKEEPING	3,205	210	373,962	0	641,065	9.00
10.00	01000	DIETARY	2,434	33,485	329,136	0	719,146	10.00
11.00	01100	CAFETERIA	2,454	30,584	300,612	0	529,273	11.00
13.00	01300	NURSING ADMINISTRATION	372	42	253,728	0	406,011	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	0	216,197	0	412,816	14.00
15.00	01500	PHARMACY	1,428	10,524	479,134	0	686,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,732	201	535,178	0	800,196	16.00
17.00	01700	SOCIAL SERVICE	0	0	251,923	0	333,760	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,292	61,368	2,459,055	0	4,318,917	30.00
43.00	04300	NURSERY	372	6,327	100,533	0	172,338	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,477	244,093	890,767	0	2,079,398	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653	7,140	113,437	0	199,439	52.00
53.00	05300	ANESTHESIOLOGY	304	7,621	0	0	36,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	291,099	1,533,673	0	3,126,267	54.00
60.00	06000	LABORATORY	4,509	70,097	953,297	0	2,781,926	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	10,696	461,912	0	674,148	65.00
66.00	06600	PHYSICAL THERAPY	5,072	18,969	1,367,883	0	1,949,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	170,386	0	226,347	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	74,008	0	99,364	68.00
69.00	06900	ELECTROCARDIOLOGY	179	41,804	211,074	0	348,664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	115,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	77,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,504,082	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,681	0	205,434	0	403,430	76.00
76.01	03950	DIABETIC EDUCATION	0	0	15,211	0	20,152	76.01
76.97	07697	CARDIAC REHABILITATION	3,915	16,566	162,869	0	329,241	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,997	40,847	1,584,496	0	3,020,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,397	1,221,365	15,966,708	-7,628,765	28,907,218	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	19,758	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	2,740,892	1,227,266	5,186,747		7,628,765	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.359486	1.004831	0.324848		0.263725	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,499		474,710	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000157		0.016411	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: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	75,455				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	201,455			8.00
9.00	00900	HOUSEKEEPING	3,205	0	71,677		9.00
10.00	01000	DIETARY	2,434	509	2,434	21,082	10.00
11.00	01100	CAFETERIA	2,454	465	2,454	0	11.00
13.00	01300	NURSING ADMINISTRATION	372	0	372	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	0	2,363	0	14.00
15.00	01500	PHARMACY	1,428	0	1,428	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,732	0	1,732	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,292	64,212	18,292	20,747	30.00
43.00	04300	NURSERY	372	1,322	372	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,477	20,733	10,477	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653	1,492	653	0	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	26,679	7,506	0	54.00
60.00	06000	LABORATORY	4,509	14	4,509	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	65.00
66.00	06600	PHYSICAL THERAPY	5,072	23,527	5,072	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	68.00
69.00	06900	ELECTROCARDIOLOGY	179	5,168	179	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,681	0	1,681	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,997	52,163	5,997	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,530	196,284	70,752	20,747	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,171	0	335	192.00
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)	3,336,657	347,008	951,857	1,049,636	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.220489	1.722509	13.279811	49.788255	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,056,523	24,445	124,124	135,848	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.002028	0.121342	1.731713	6.443791	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: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	177,675					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,724,494				14.00
15.00	01500	PHARMACY	0	3,829	1,504,082			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	86	0	3,963		16.00
17.00	01700	SOCIAL SERVICE	5,986	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,681	169,432	0	540	100	30.00
43.00	04300	NURSERY	2,098	1,568	0	67	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,864	226,580	0	486	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,367	1,769	0	20	0	52.00
53.00	05300	ANESTHESIOLOGY	7,259	16,498	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,062	0	323	0	54.00
60.00	06000	LABORATORY	0	786,729	0	298	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,139	0	58	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,414	0	38	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	575	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,941	0	61	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	115,549	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	77,117	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,504,082	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	84	0	25	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	10	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	2,350	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	49,420	187,772	0	2,027	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	177,675	1,724,494	1,504,082	3,953	100	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	10	0	192.00
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)	546,902	678,799	974,883	1,161,312	452,554	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.078103	0.393622	0.648158	293.038607	4,525.540000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,545	97,880	78,854	85,794	8,265	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.126889	0.056759	0.052427	21.648751	82.650000	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: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0		30.00
43.00	04300	NURSERY	0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		76.00
76.01	03950	DIABETIC EDUCATION	0		76.01
76.97	07697	CARDIAC REHABILITATION	0		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0		118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-2

Date/Time Prepared:
3/26/2021 8:04 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		ADULTS & PEDIATRICS		1	30.00	-588,443 7.00
8.00		OPERATING ROOM		1	64.00	588,443 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 8:04 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	8,173,728		8,173,728	0	0	30.00	
43.00	04300	NURSERY	273,841		273,841	0	0	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,640,591		3,640,591	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	312,389		312,389	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	107,181		107,181	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,649,150		4,649,150	0	0	54.00	
60.00	06000	LABORATORY	4,253,189		4,253,189	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	588,443		588,443	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	957,558	0	957,558	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,894,436	0	2,894,436	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	294,921	0	294,921	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	135,193	0	135,193	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	493,005		493,005	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	191,505		191,505	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	127,810		127,810	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,875,629		2,875,629	0	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	626,229		626,229	0	0	76.00	
76.01	03950	DIABETIC EDUCATION	28,397		28,397	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	651,914		651,914	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	5,173,959		5,173,959	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	626,462		626,462		0	92.00	
200.00		Subtotal (see instructions)	37,075,530	0	37,075,530	0	0	200.00	
201.00		Less Observation Beds	626,462		626,462		0	201.00	
202.00		Total (see instructions)	36,449,068	0	36,449,068	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 8:04 am

			Title XVIII		Hospital	Cost		
	Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,457,465		6,457,465			30.00
43.00	04300	NURSERY	276,750		276,750			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	768,656	7,111,443	7,880,099	0.461998	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,228,774	482,982	1,711,756	0.182496	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	228,479	846,771	1,075,250	0.099680	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,093,221	38,623,371	39,716,592	0.117058	0.000000	54.00
60.00	06000	LABORATORY	2,728,661	14,777,095	17,505,756	0.242959	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,320,283	400,290	3,720,573	0.158159	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	809,999	1,832,597	2,642,596	0.362355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	622,101	4,464,858	5,086,959	0.568991	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	443,809	369,548	813,357	0.362597	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	42,374	334,796	377,170	0.358440	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	343,405	3,783,320	4,126,725	0.119466	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	950,405	996,280	1,946,685	0.098375	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,426	360,969	481,395	0.265499	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,218,378	6,665,319	8,883,697	0.323697	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	267,613	267,613	2.340054	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	46	104,184	104,230	0.272446	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	463	1,075,471	1,075,934	0.605905	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	656,100	19,936,828	20,592,928	0.251249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,233	1,168,669	1,202,902	0.520792	0.000000	92.00
200.00		Subtotal (see instructions)	22,344,028	103,602,404	125,946,432			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,344,028	103,602,404	125,946,432			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03950	DIABETIC EDUCATION	0.000000			76.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	708,319	7,880,099	0.089887	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,730	1,711,756	0.021457	2,202	47
53.00	05300	ANESTHESIOLOGY	23,792	1,075,250	0.022127	10,002	221
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,537	39,716,592	0.016430	489,222	8,038
60.00	06000	LABORATORY	347,737	17,505,756	0.019864	991,413	19,693
64.00	06400	INTRAVENOUS THERAPY	0	3,720,573	0.000000	1,368,399	0
65.00	06500	RESPIRATORY THERAPY	62,661	2,642,596	0.023712	412,231	9,775
66.00	06600	PHYSICAL THERAPY	257,050	5,086,959	0.050531	141,487	7,149
67.00	06700	OCCUPATIONAL THERAPY	5,169	813,357	0.006355	78,128	497
68.00	06800	SPEECH PATHOLOGY	6,199	377,170	0.016436	26,354	433
69.00	06900	ELECTROCARDIOLOGY	58,775	4,126,725	0.014243	178,412	2,541
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,454	1,946,685	0.004343	403,249	1,751
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,643	481,395	0.011722	4,182	49
73.00	07300	DRUGS CHARGED TO PATIENTS	103,537	8,883,697	0.011655	740,364	8,629
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	71,546	267,613	0.267349	0	0
76.01	03950	DIABETIC EDUCATION	549	104,230	0.005267	0	0
76.97	07697	CARDIAC REHABILITATION	169,007	1,075,934	0.157079	347	55
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	396,818	20,592,928	0.019270	364	7
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,684	1,202,902	0.066243	8,960	594
200.00		Total (lines 50 through 199)	2,994,207	119,212,217		4,855,316	59,479

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	7,880,099	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,711,756	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,075,250	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,716,592	0.000000
60.00	06000	LABORATORY	0	0	0	17,505,756	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,720,573	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,642,596	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	5,086,959	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	813,357	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	377,170	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,126,725	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,946,685	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	481,395	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,883,697	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	267,613	0.000000
76.01	03950	DIABETIC EDUCATION	0	0	0	104,230	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,075,934	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	20,592,928	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,202,902	0.000000
200.00		Total (lines 50 through 199)	0	0	0	119,212,217	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,202	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,002	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	489,222	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	991,413	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,368,399	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	412,231	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	141,487	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	78,128	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	26,354	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	178,412	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	403,249	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,182	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	740,364	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	347	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	364	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	8,960	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,855,316	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
3/26/2021 8:04 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.461998	0	1,932,087	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182496	0	1,351	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.099680	0	193,908	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117058	0	12,691,639	0	0	0	54.00
60.00	06000	LABORATORY	0.242959	0	4,793,376	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158159	0	147,287	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.362355	0	620,058	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.568991	0	1,203,389	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362597	0	63,990	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.358440	0	30,761	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.119466	0	1,527,911	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098375	0	211,593	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.265499	0	179,347	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323697	0	3,547,858	5,226	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.340054	0	114,371	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.272446	0	26,808	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.605905	0	629,049	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.251249	0	5,989,793	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.520792	0	554,999	0	0	0	92.00
200.00		Subtotal (see instructions)		0	34,459,575	5,226	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	34,459,575	5,226		0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1322		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 3/26/2021 8:04 am	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	892,620	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	247	0					52.00
53.00	05300	ANESTHESIOLOGY	19,329	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,485,658	0					54.00
60.00	06000	LABORATORY	1,164,594	0					60.00
64.00	06400	INTRAVENOUS THERAPY	23,295	0					64.00
65.00	06500	RESPIRATORY THERAPY	224,681	0					65.00
66.00	06600	PHYSICAL THERAPY	684,718	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	23,203	0					67.00
68.00	06800	SPEECH PATHOLOGY	11,026	0					68.00
69.00	06900	ELECTROCARDIOLOGY	182,533	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,815	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,616	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,148,431	1,692					73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	267,634	0					76.00
76.01	03950	DIABETIC EDUCATION	7,304	0					76.01
76.97	07697	CARDIAC REHABILITATION	381,144	0					76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	1,504,930	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	289,039	0					92.00
200.00		Subtotal (see instructions)	8,378,817	1,692					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	8,378,817	1,692					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 8:04 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,878	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,020	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)			2,657	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			426	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)			1,276	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			39	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)			117	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,484	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)			358	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)			1,074	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			8,173,728	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)			6,130	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)			18,391	25.00
26.00	Total swing-bed cost (see instructions)			2,961,833	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,211,895	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)			5,211,895	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,725.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,561,087	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)			2,561,087	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
3/26/2021 8:04 am

		Title XVIII		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)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,090,333
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,651,420
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					617,836
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,853,509
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,471,345
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					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)					363
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,725.79
89.00	Observation bed cost (line 87 x line 88) (see instructions)					626,462

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
3/26/2021 8:04 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,039,677	8,173,728	0.127197	626,462	79,684	90.00
91.00	Nursing School cost	0	8,173,728	0.000000	626,462	0	91.00
92.00	Allied health cost	0	8,173,728	0.000000	626,462	0	92.00
93.00	All other Medical Education	0	8,173,728	0.000000	626,462	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 3/26/2021 8:04 am	
			Title XVIII	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		2,662,637		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.461998	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182496	2,202	402	52.00
53.00	05300	ANESTHESIOLOGY	0.099680	10,002	997	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117058	489,222	57,267	54.00
60.00	06000	LABORATORY	0.242959	991,413	240,873	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158159	1,368,399	216,425	64.00
65.00	06500	RESPIRATORY THERAPY	0.362355	412,231	149,374	65.00
66.00	06600	PHYSICAL THERAPY	0.568991	141,487	80,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362597	78,128	28,329	67.00
68.00	06800	SPEECH PATHOLOGY	0.358440	26,354	9,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0.119466	178,412	21,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098375	403,249	39,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.265499	4,182	1,110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323697	740,364	239,654	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.340054	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.272446	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.605905	347	210	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.251249	364	91	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.520792	8,960	4,666	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,855,316	1,090,333	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,855,316		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3
			Component CCN: 14-Z322		Date/Time Prepared: 3/26/2021 8:04 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.461998	2,576	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182496	0	52.00
53.00	05300	ANESTHESIOLOGY	0.099680	2,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117058	150,797	54.00
60.00	06000	LABORATORY	0.242959	515,113	60.00
64.00	06400	INTRAVENOUS THERAPY	0.158159	750,308	64.00
65.00	06500	RESPIRATORY THERAPY	0.362355	135,878	65.00
66.00	06600	PHYSICAL THERAPY	0.568991	300,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.362597	243,803	67.00
68.00	06800	SPEECH PATHOLOGY	0.358440	5,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0.119466	9,054	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098375	150,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.265499	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323697	488,655	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.340054	0	76.00
76.01	03950	DIABETIC EDUCATION	0.272446	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.605905	116	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.251249	141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.520792	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,755,792	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)		2,755,792	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 3/26/2021 8:04 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			8,380,509 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			8,380,509 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)			8,464,314 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			49,226 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,868,818 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,546,270 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,546,270 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			2,546,270 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)			611,369 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			397,390 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			96,356 36.00
37.00	Subtotal (see instructions)			2,943,660 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,943,660 40.00
40.01	Sequestration adjustment (see instructions)			34,146 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			2,276,583 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)			632,931 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: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
3/26/2021 8:04 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,886,184		3,208,108	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	09/01/2020	248,101	09/01/2020	931,525	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)		-248,101		-931,525	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)		3,638,083		2,276,583	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		632,931	6.01
6.02	SETTLEMENT TO PROGRAM		306,461		0	6.02
7.00	Total Medicare program liability (see instructions)		3,331,622		2,909,514	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1322

Period:

Worksheet E-1

Component CCN: 14-Z322

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
3/26/2021 8:04 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,465,343		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/01/2020	90,889		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)		-90,889		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)		3,374,454		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		228,438		0	6.02
7.00	Total Medicare program liability (see instructions)		3,146,016		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part II
Date/Time Prepared:
3/26/2021 8:04 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2
		Component CCN: 14-Z322		Date/Time Prepared: 3/26/2021 8:04 am
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,496,058	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		755,152	0 3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00 4.00
5.00	Program days		1,432	0 5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0 6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3,251,210	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		3,251,210	0 10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0 11.00
12.00	Subtotal (line 10 minus line 11)		3,251,210	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		68,272	0 13.00
14.00	80% of Part B costs (line 12 x 80%)			0 14.00
15.00	Subtotal (see instructions)		3,182,938	0 15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0	16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0 16.99
17.00	Allowable bad debts (see instructions)		0	0 17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0 17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0 18.00
19.00	Total (see instructions)		3,182,938	0 19.00
19.01	Sequestration adjustment (see instructions)		36,922	0 19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0 19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments		3,374,454	0 20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		0	0 21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-228,438	0 22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1322	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 3/26/2021 8:04 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,651,420	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,651,420	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,687,934	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,687,934	19.00
20.00	Deductibles (exclude professional component)		344,652	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,343,282	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,343,282	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		42,216	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		27,440	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,414	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,370,722	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		3,370,722	30.00
30.01	Sequestration adjustment (see instructions)		39,100	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		3,638,083	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-306,461	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet G

Date/Time Prepared:
3/26/2021 8:04 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	17,364,874	0	0	0	1.00
2.00	Temporary investments	1,968,773	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,816,600	0	0	0	4.00
5.00	Other receivable	133,949	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,559,085	0	0	0	6.00
7.00	Inventory	665,687	0	0	0	7.00
8.00	Prepaid expenses	311,954	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,041	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,703,793	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,421,216	0	0	0	12.00
13.00	Land improvements	6,078,200	0	0	0	13.00
14.00	Accumulated depreciation	-4,295,503	0	0	0	14.00
15.00	Buildings	44,650,230	0	0	0	15.00
16.00	Accumulated depreciation	-24,552,878	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	18,424,573	0	0	0	23.00
24.00	Accumulated depreciation	-14,369,833	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	247,095	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,603,100	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	74,470,389	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	32,222,606	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	106,692,995	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	159,999,888	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,187,788	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,785,590	0	0	0	38.00
39.00	Payroll taxes payable	874	0	0	0	39.00
40.00	Notes and loans payable (short term)	-3,957,824	0	0	0	40.00
41.00	Deferred income	5,761,255	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	217,042	0	0	0	43.00
44.00	Other current liabilities	50,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,044,725	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,044,725	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	153,955,163				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	153,955,163	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	159,999,888	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
3/26/2021 8:04 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		134,290,711		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		20,879,091				2.00
3.00	Total (sum of line 1 and line 2)		155,169,802		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		155,169,802		0		11.00
12.00	CHANGE IN RESTRICTED ASSETS	1,214,639		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)		1,214,639		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		153,955,163		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN RESTRICTED ASSETS		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: 14-1322

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
3/26/2021 8:04 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,071,949		4,071,949	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,235,544		2,235,544	5.00
6.00	Swing bed - NF	204,903		204,903	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)	6,512,396		6,512,396	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,512,396		6,512,396	17.00
18.00	Ancillary services	15,067,313	84,291,539	99,358,852	18.00
19.00	Outpatient services	696,556	21,342,165	22,038,721	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	283,500	0	283,500	27.00
27.01	PROFESSIONAL FEES	841,564	11,461,469	12,303,033	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,401,329	117,095,173	140,496,502	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,860,864		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)		42,860,864		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
3/26/2021 8:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	140,496,502	1.00
2.00	Less contractual allowances and discounts on patients' accounts	89,602,965	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,893,537	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,860,864	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,032,673	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	157,231	6.00
7.00	Income from investments	866,282	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	734	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	132,483	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	961	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	3,405	22.00
23.00	Governmental appropriations	0	23.00
24.00	REALIZED GAIN/LOSS ON INVESTMENTS	2,440,798	24.00
24.01	UNREALIZED GAIN/LOSS ON INVESTMENTS	4,241,848	24.01
24.02	CHANGE IN INTEREST IN FOUNDATION	1,107,645	24.02
24.03	PROVISION FOR INCOME TAXES	26,069	24.03
24.04	MISCELLANEOUS INCOME	59,511	24.04
24.05	FOUNDATION OTHER GAINS/LOSSES	2,112	24.05
24.50	COVID-19 PHE Funding	3,977,557	24.50
25.00	Total other income (sum of lines 6-24)	13,016,636	25.00
26.00	Total (line 5 plus line 25)	21,049,309	26.00
27.00	CONTRIBUTIONS	150,000	27.00
27.01	INVESTMENT FEES	14,840	27.01
27.02	SALE OF AR TRUST FEES	5,378	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	170,218	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	20,879,091	29.00