

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: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet 5 Parts I-III Date/Time Prepared: 9/10/2020 11:43 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/10/2020	Time: 11:43 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 LINCOLN PRAIRIE (14-4013) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 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.

Encryption Information

ECR: Date: 9/10/2020 Time: 11:43 am
p19uXBuULCEU4yqUpfeh:z0LCEUKMO
wRMF.0qjEHV617A7ydk4.vJ11bQs
RZdCOnLGGe08X:KP
PI: Date: 9/10/2020 Time: 11:43 am
wOttivEciuHo80iSVKE2FvM0xgyXq0
H1gDn0zGE0CFqHR542wYrmAwa27zSh
9J.80oHtBP0YfyVd

(Signed)

Officer or Administrator of Provider(s)

SVP & CFO

Title

9/15/2020

Date

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	0	0	-8,017,135	1.00
2.00 Subprovider - IPF	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	3.00
5.00 Swing Bed - SNF	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	6.00
12.00 CMHC I	0	0	0	0	12.00
200.00 Total	0	0	0	-8,017,135	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.

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

OMB NO. 0938-0050

EXPIRES 03-31-2022

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

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet S
Parts I-III
Date/Time Prepared:
9/10/2020 11:43 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/10/2020	Time: 11:43 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LINCOLN PRAIRIE (14-4013) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 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)

Officer or Administrator of Provider(s)_____
Title_____
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	-8,017,135	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0		0		0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	0	0	0	-8,017,135	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: 14-4013		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/10/2020 11:43 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5230 S 6TH ST.			PO Box:				1.00	
2.00	City: SPRINGFIELD			State: IL		Zip Code: 62703		County: SANGAMON	
		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			LINCOLN PRAIRIE	144013	44100	4	05/15/2008	N
4.00	Subprovider - IPF								N
5.00	Subprovider - IRF								O
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2019	04/30/2020	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		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: 14-4013		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/10/2020 11:43 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/10/2020 11:43 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/10/2020 11:43 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/10/2020 11:43 am	
			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/10/2020 11:43 am	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				N		112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	Y		B		0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		0118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N		118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N		122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/10/2020 11:43 am	
		1.00		2.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		399001		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: UNIVERSAL HEALTH SERVICES	Contractor's Name: 399001		Contractor's Number: 399001		141.00	
142.00	Street: 367 SOUTH GULPH ROAD	PO Box: P.O. BOX		Zip Code: 19406		142.00	
143.00	City: KING OF PRUSSIA	State: PA				143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.10	CORF			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	
		0		1.00		2.00	
						3.00	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/10/2020 11:43 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4013		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part II Date/Time Prepared: 9/10/2020 11:43 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)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/10/2020 11:43 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y	Y		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	DEANNA	SANDOVAL		41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	629-208-5506	DEANNA.SANDOVAL@UHSINC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 9/10/2020 11:43 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/10/2020 11:43 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	97	35,502	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		97	35,502	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		97	35,502	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			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	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		97				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: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/10/2020 11:43 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)	0	11,462	26,224		1.00
2.00	HMO and other (see instructions)	0	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	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	11,462	26,224		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	11,462	26,224	0.00	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			0	0.00	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	0	0	0	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	25.10
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		0	0		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/10/2020 11:43 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	0	707	2,178	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	0	707	2,178	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	0.00				0	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	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		964,220	964,220	0	964,220 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		163,728	163,728	2,435	166,163 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	90,166	1,833,182	1,923,348	0	1,923,348 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,165,803	4,401,832	6,567,635	-436,980	6,130,655 5.00
7.00	00700	OPERATION OF PLANT	169,099	814,599	983,698	0	983,698 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,270	154,270	0	154,270 8.00
9.00	00900	HOUSEKEEPING	0	241,821	241,821	0	241,821 9.00
10.00	01000	DIETARY	251,025	389,896	640,921	0	640,921 10.00
13.00	01300	NURSING ADMINISTRATION	699,660	15,909	715,569	0	715,569 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,038	155,433	256,471	0	256,471 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,235,604	542,404	4,778,008	-146,430	4,631,578 30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
93.00	04950	IOP	118,657	23,980	142,637	146,430	289,067 93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	382,731	21,500	404,231	0	404,231 93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0 99.00
99.10	09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,213,783	9,722,774	17,936,557	-434,545	17,502,012 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	07951	EDUCATION	125,762	248	126,010	0	126,010 194.01
194.02	07952	COMMUNITY RELATIONS	0	0	0	434,545	434,545 194.02
194.03	07953	PHP MEALS	0	0	0	0	0 194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	8,339,545	9,723,022	18,062,567	0	18,062,567 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/10/2020 11:43 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	-142,331	821,889	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,215	174,378	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-397,843	1,525,505	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,428,873	3,701,782	5.00
7.00	00700	OPERATION OF PLANT	0	983,698	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,270	8.00
9.00	00900	HOUSEKEEPING	0	241,821	9.00
10.00	01000	DIETARY	-3,205	637,716	10.00
13.00	01300	NURSING ADMINISTRATION	0	715,569	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,132	248,339	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,631,578	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	IOP	0	289,067	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	404,231	93.99
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,972,169	14,529,843	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	126,010	194.01
194.02	07952	COMMUNITY RELATIONS	0	434,545	194.02
194.03	07953	PHP MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,972,169	15,090,398	200.00

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
9/10/2020 11:43 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,435	1.00	
	0		0	2,435		
	B - COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	194.02	297,661	136,884	1.00	
	0		297,661	136,884		
	C - PHARMACY/SOCIAL SERVICE					
1.00	IOP	93.00	123,223	23,207	1.00	
	TOTALS		123,223	23,207		
500.00	Grand Total: Increases		420,884	162,526	500.00	

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
9/10/2020 11:43 am

	Decreases						07/10/2020 11:40 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,435	10		1.00
	0		0	2,435			
	B - COMMUNITY RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	297,661	136,884	0		1.00
	0		297,661	136,884			
	C - PHARMACY/SOCIAL SERVICE						
1.00	ADULTS & PEDIATRICS	30.00	123,223	23,207	0		1.00
	TOTALS		123,223	23,207			
500.00	Grand Total: Decreases		420,884	162,526			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
9/10/2020 11:43 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,203,487	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,707,331	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,190,373	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,101,191	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,101,191	0	0	0	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,203,487	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	13,707,331	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	1,190,373	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	18,101,191	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	18,101,191	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
9/10/2020 11:43 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	753,778	0	0	17,649	192,793	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	159,231	0	0	4,497	0	2.00
3.00	Total (sum of lines 1-2)	913,009	0	0	22,146	192,793	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	964,220				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	163,728				2.00
3.00	Total (sum of lines 1-2)	0	1,127,948				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
9/10/2020 11:43 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	13,707,331	0	13,707,331	0.920097	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,190,373	0	1,190,373	0.079903	0	2.00
3.00	Total (sum of lines 1-2)	14,897,704	0	14,897,704	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	611,447	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	167,446	2,435	2.00
3.00	Total (sum of lines 1-2)	0	0	0	778,893	2,435	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	17,649	192,793	0	821,889	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,497	0	0	174,378	2.00
3.00	Total (sum of lines 1-2)	0	22,146	192,793	0	996,267	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/10/2020 11:43 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-38,473	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,550,433			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-72,432			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-3,205	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,132	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*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-142,331	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	8,215	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/10/2020 11:43 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 #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC ADMIN REVENUE	B	-16,100	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	REBATES - ADD BACK	A	38,473	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN BILLING	A	-66,917	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	HOSPITAL PAID MALPRACTICE	A	-4,904	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	LOBBYING	A	-4,816	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	BAD DEBTS	A	-160,120	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	DONATIONS	A	-616	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	PATIENT TRANSPORTATION	A	-337,595	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	EMPLOYED PHYSICIAN BENEFITS	A	-298,854	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	GAIN/LOSS ON DISPOSAL	A	3,375	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	STATE INCOME TAX	A	-316,593	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	SPOUSAL TRAVEL	A	-711	ADMINISTRATIVE & GENERAL	5.00	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,972,169				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: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
9/10/2020 11:43 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	801,744	813,440 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	INTERCO INTEREST	0	-159,520 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	135,600	234,589 3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	NRO MGMT FEE	17,978	17,978 3.01
4.00		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	0	121,267 4.00
5.00	0				955,322	1,027,754 5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	UNIVERSAL HEALT	100.00	UNIVERSAL HEALT	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
9/10/2020 11:43 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	-11,696	0		1.00
2.00	159,520	0		2.00
3.00	-98,989	0		3.00
3.01	0	0		3.01
4.00	-121,267	0		4.00
5.00	-72,432			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	HEALTH CARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-2

Date/Time Prepared:
9/10/2020 11:43 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	5.00	ADMINISTRATIVE & GENERAL	1,550,433	1,550,433	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,550,433	1,550,433	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,550,433		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,550,433		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
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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	821,889	821,889			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	174,378	174,378			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,525,505	3,356	712	1,529,573	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,701,782	86,902	18,438	346,385	4,153,507
7.00	00700	OPERATION OF PLANT	983,698	128,930	27,355	31,354	1,171,337
8.00	00800	LAUNDRY & LINEN SERVICE	154,270	2,372	503	0	157,145
9.00	00900	HOUSEKEEPING	241,821	5,025	1,066	0	247,912
10.00	01000	DIETARY	637,716	32,478	6,891	46,544	723,629
13.00	01300	NURSING ADMINISTRATION	715,569	6,712	1,424	129,729	853,434
16.00	01600	MEDICAL RECORDS & LIBRARY	248,339	9,514	2,019	18,734	278,606
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,631,578	497,501	105,553	762,504	5,997,136
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
93.00	04950	IOP	289,067	29,421	6,242	44,849	369,579
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	404,231	15,567	3,303	70,965	494,066
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,529,843	817,778	173,506	1,451,064	14,446,351
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	126,010	2,249	477	23,318	152,054
194.02	07952	COMMUNITY RELATIONS	434,545	1,862	395	55,191	491,993
194.03	07953	PHP MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	15,090,398	821,889	174,378	1,529,573	15,090,398

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/10/2020 11:43 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	4,153,507					5.00
7.00	00700	OPERATION OF PLANT	444,839	1,616,176				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,679	6,361	223,185			8.00
9.00	00900	HOUSEKEEPING	94,150	13,475	0	355,537		9.00
10.00	01000	DIETARY	274,813	87,093	0	19,397	1,104,932	10.00
13.00	01300	NURSING ADMINISTRATION	324,109	17,998	0	4,009	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	105,806	25,513	0	5,682	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,277,535	1,334,072	223,185	297,126	1,045,565	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	140,355	78,895	0	17,571	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	187,631	41,744	0	9,297	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,908,917	1,605,151	223,185	353,082	1,045,565	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	57,746	6,031	0	1,343	0	194.01
194.02	07952	COMMUNITY RELATIONS	186,844	4,994	0	1,112	0	194.02
194.03	07953	PHP MEALS	0	0	0	0	59,367	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,153,507	1,616,176	223,185	355,537	1,104,932	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description			NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	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
13.00	01300	NURSING ADMINISTRATION	1,199,550					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	415,607				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,199,550	387,483	12,761,652	0	12,761,652	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	0	5,012	611,412	0	611,412	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	23,112	755,850	0	755,850	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,199,550	415,607	14,128,914	0	14,128,914	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	217,174	0	217,174	194.01
194.02	07952	COMMUNITY RELATIONS	0	0	684,943	0	684,943	194.02
194.03	07953	PHP MEALS	0	0	59,367	0	59,367	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,199,550	415,607	15,090,398	0	15,090,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,356	712	4,068	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	86,902	18,438	105,340	5.00
7.00	00700	OPERATION OF PLANT	0	128,930	27,355	156,285	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,372	503	2,875	8.00
9.00	00900	HOUSEKEEPING	0	5,025	1,066	6,091	9.00
10.00	01000	DIETARY	0	32,478	6,891	39,369	10.00
13.00	01300	NURSING ADMINISTRATION	0	6,712	1,424	8,136	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,514	2,019	11,533	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	497,501	105,553	603,054	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	0	29,421	6,242	35,663	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	15,567	3,303	18,870	93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	817,778	173,506	991,284	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	0	2,249	477	2,726	194.01
194.02	07952	COMMUNITY RELATIONS	0	1,862	395	2,257	194.02
194.03	07953	PHP MEALS	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	821,889	174,378	996,267	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/10/2020 11:43 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	106,261					5.00
7.00	00700	OPERATION OF PLANT	11,381	167,749				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,527	660	5,062			8.00
9.00	00900	HOUSEKEEPING	2,409	1,399	0	9,899		9.00
10.00	01000	DIETARY	7,031	9,040	0	540	56,104	10.00
13.00	01300	NURSING ADMINISTRATION	8,292	1,868	0	112	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,707	2,648	0	158	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,266	138,468	5,062	8,273	53,090	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	3,591	8,189	0	489	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	4,800	4,333	0	259	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,004	166,605	5,062	9,831	53,090	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	1,477	626	0	37	0	194.01
194.02	07952	COMMUNITY RELATIONS	4,780	518	0	31	0	194.02
194.03	07953	PHP MEALS	0	0	0	0	3,014	194.03
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)	106,261	167,749	5,062	9,899	56,104	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description			NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	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
13.00	01300	NURSING ADMINISTRATION	18,753					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,096				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,753	15,940	902,934	0	902,934	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	0	206	48,257	0	48,257	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	950	29,401	0	29,401	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,753	17,096	980,592	0	980,592	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	4,928	0	4,928	194.01
194.02	07952	COMMUNITY RELATIONS	0	0	7,733	0	7,733	194.02
194.03	07953	PHP MEALS	0	0	3,014	0	3,014	194.03
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)	18,753	17,096	996,267	0	996,267	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	93,555					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		93,555				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	382	382	8,249,379			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,892	9,892	1,868,142	-4,153,507	10,936,891	5.00
7.00	00700	OPERATION OF PLANT	14,676	14,676	169,099	0	1,171,337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	270	270	0	0	157,145	8.00
9.00	00900	HOUSEKEEPING	572	572	0	0	247,912	9.00
10.00	01000	DIETARY	3,697	3,697	251,025	0	723,629	10.00
13.00	01300	NURSING ADMINISTRATION	764	764	699,660	0	853,434	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,083	1,083	101,038	0	278,606	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,630	56,630	4,112,381	0	5,997,136	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	3,349	3,349	241,880	0	369,579	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,772	1,772	382,731	0	494,066	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,087	93,087	7,825,956	-4,153,507	10,292,844	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	256	256	125,762	0	152,054	194.01
194.02	07952	COMMUNITY RELATIONS	212	212	297,661	0	491,993	194.02
194.03	07953	PHP MEALS	0	0	0	0	0	194.03
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)	821,889	174,378	1,529,573		4,153,507	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.785089	1.863909	0.185417		0.379770	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,068		106,261	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000493		0.009716	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: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS)	NURSING ADMINISTRATION (PT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	68,605				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	270	26,224			8.00
9.00	00900	HOUSEKEEPING	572	0	67,763		9.00
10.00	01000	DIETARY	3,697	0	3,697	83,139	10.00
13.00	01300	NURSING ADMINISTRATION	764	0	764	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,083	0	1,083	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,630	26,224	56,630	78,672	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	3,349	0	3,349	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,772	0	1,772	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,137	26,224	67,295	78,672	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	256	0	256	0	194.01
194.02	07952	COMMUNITY RELATIONS	212	0	212	0	194.02
194.03	07953	PHP MEALS	0	0	0	4,467	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,616,176	223,185	355,537	1,104,932	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.557700	8.510715	5.246772	13.290177	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	167,749	5,062	9,899	56,104	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.445142	0.193029	0.146083	0.674822	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: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (CHARGES)	
		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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		43,446,449	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		0	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
93.00	04950	IOP	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
		523,958	
		2,416,106	
OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
		0	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		43,446,449	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	COMMUNITY RELATIONS	194.02
194.03	07953	PHP MEALS	194.03
		0	
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		415,607	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.009566	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		17,096	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000393	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/10/2020 11:43 am

				Title XVIII		Hospital			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,761,652		12,761,652	0	0	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00	
60.00	06000	LABORATORY	0		0	0	0	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
93.00	04950	IOP	611,412		611,412	0	0	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	755,850		755,850	0	0	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0		0		0	99.00	
99.10	09910	CORF	0		0		0	99.10	
200.00		Subtotal (see instructions)	14,128,914	0	14,128,914	0	0	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	14,128,914	0	14,128,914	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/10/2020 11:43 am

					Title XVIII		Hospital			
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	40,506,385		40,506,385			30.00		
46.00	04600	OTHER LONG TERM CARE	0		0			46.00		
	ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00		
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00		
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00		
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00		
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00		
93.00	04950	IOP	0	523,958	523,958	1.166910	0.000000	93.00		
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	2,416,106	2,416,106	0.312838	0.000000	93.99		
	OTHER REIMBURSABLE COST CENTERS									
99.00	09900	CMHC	0	0	0			99.00		
99.10	09910	CORF	0	0	0			99.10		
200.00		Subtotal (see instructions)	40,506,385	2,940,064	43,446,449			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	40,506,385	2,940,064	43,446,449			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet C Part I Date/Time Prepared: 9/10/2020 11:43 am
				Title XVIII	Hospital	
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
93.00	04950	IOP	0.000000			93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
	OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/10/2020 11:43 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,761,652		12,761,652	0	12,761,652	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00	
60.00	06000	LABORATORY	0		0	0	0	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
93.00	04950	IOP	611,412		611,412	0	611,412	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	755,850		755,850	0	755,850	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0		0		0	99.00	
99.10	09910	CORF	0		0		0	99.10	
200.00		Subtotal (see instructions)	14,128,914	0	14,128,914	0	14,128,914	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	14,128,914	0	14,128,914	0	14,128,914	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/10/2020 11:43 am

					Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,506,385		40,506,385			30.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
93.00	04950	IOP	0	523,958	523,958	1.166910	0.000000	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	2,416,106	2,416,106	0.312838	0.000000	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0			99.00	
99.10	09910	CORF	0	0	0			99.10	
200.00		Subtotal (see instructions)	40,506,385	2,940,064	43,446,449			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	40,506,385	2,940,064	43,446,449			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN:14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet C Part I Date/Time Prepared: 9/10/2020 11:43 am
				Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
93.00	04950	IOP	0.000000			93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
	OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/10/2020 11:43 am
		Title XIX	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		26,224	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,224	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)		26,224	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		11,462	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,761,652	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12,761,652	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)		12,761,652	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)		486.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,577,868	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)		5,577,868	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,577,868	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4013		Period: From 05/01/2019 To 04/30/2020		Worksheet D-1 Date/Time Prepared: 9/10/2020 11:43 am	
		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	902,934	12,761,652	0.070754	0	0	90.00
91.00	Nursing School cost	0	12,761,652	0.000000	0	0	91.00
92.00	Allied health cost	0	12,761,652	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,761,652	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/10/2020 11:43 am	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		17,779,481		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 IOP	1.166910	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.312838	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4013	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 9/10/2020 11:43 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	5,577,868		1.00	
2.00	Medical and other services		0	2.00	
3.00	Organ acquisition (certified transplant centers only)	0		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)	5,577,868	0	4.00	
5.00	Inpatient primary payer payments	0		5.00	
6.00	Outpatient primary payer payments		0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	5,577,868	0	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	17,779,481		8.00	
9.00	Ancillary service charges	0	0	9.00	
10.00	Organ acquisition charges, net of revenue	0		10.00	
11.00	Incentive from target amount computation	0		11.00	
12.00	Total reasonable charges (sum of lines 8 through 11)	17,779,481	0	12.00	
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00	
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00	
16.00	Total customary charges (see instructions)	17,779,481	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	12,201,613	0	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00	
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	5,577,868	0	21.00	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0	0	22.00	
23.00	Outlier payments	0	0	23.00	
24.00	Program capital payments	0		24.00	
25.00	Capital exception payments (see instructions)	0		25.00	
26.00	Routine and Ancillary service other pass through costs	0	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	0		28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)	5,577,868	0	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	5,577,868	0	31.00	
32.00	Deductibles	0		32.00	
33.00	Coinsurance	0		33.00	
34.00	Allowable bad debts (see instructions)	0		34.00	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	5,577,868	0	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00	
38.00	Subtotal (line 36 ± line 37)	5,577,868	0	38.00	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	5,577,868	0	40.00	
41.00	Interim payments	13,595,003	0	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	-8,017,135	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00	

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

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet G

Date/Time Prepared:
9/10/2020 11:43 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	-53,930	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,098,165	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	42,297	0	0	0	7.00
8.00	Prepaid expenses	73,726	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,160,258	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,203,487	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	14,948,455	0	0	0	15.00
16.00	Accumulated depreciation	-6,949,383	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,378,425	0	0	0	23.00
24.00	Accumulated depreciation	-819,798	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,761,186	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,381,478	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,381,478	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,302,922	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	166,511	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,036,285	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-118,583,509	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-117,380,713	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)	-117,380,713	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	134,683,635	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	134,683,635	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,302,922	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-1

Date/Time Prepared:
9/10/2020 11:43 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		118,458,073		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,225,564				2.00
3.00	Total (sum of line 1 and line 2)		134,683,637		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)		134,683,637		0		11.00
12.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		134,683,635		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	ROUNDING		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: 14-4013

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/10/2020 11:43 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	40,506,385		40,506,385	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	40,506,385		40,506,385	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)	40,506,385		40,506,385	17.00
18.00	Ancillary services	0		0	18.00
19.00	Outpatient services	0	2,940,064	2,940,064	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		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,506,385	2,940,064	43,446,449	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,062,567		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	PHYSICIAN	3,204,050			37.00
38.00	EDUCATION	517,978			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)		3,722,028		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,340,539		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-3

Date/Time Prepared:
9/10/2020 11:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,446,449	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,907,784	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,538,665	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,340,539	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,198,126	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	27,438	24.00
25.00	Total other income (sum of lines 6-24)	27,438	25.00
26.00	Total (line 5 plus line 25)	16,225,564	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,225,564	29.00