

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: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 10/15/2020 3:52 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 10/15/2020	Time: 3:52 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GARFIELD PARK HOSPITAL (14-4039) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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) STEVE FILTON

Officer or Administrator of Provider(s)

SVP & CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	-3,405,649	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	0	0	0	-3,405,649	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: 14-4039		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 10/15/2020 3:52 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 520 NORTH RIDGEWAY AVE			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60624		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			GARFIELD PARK HOSPITAL	144039	16974	4	06/27/2013	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		
				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: 14-4039		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 10/15/2020 3:52 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
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 St	Date of Geogra		
							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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

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

MCRIF32 - 16.3.168.2

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	Y	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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	51,730118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB2125	140.00

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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, INC			Contractor's Name: NOVITAS			Contractor's Number: 12001		141.00			
142.00	Street: 367 S. GULPH RD			PO Box:					142.00			
143.00	City: KING OF PRUSSIA			State: PA			Zip Code: 19406		143.00			
									1.00			
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00		
									1.00			
									2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N		145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00			
									1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00		
				Part A		Part B		Title V		Title XIX		
				1.00		2.00		3.00		4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)												
155.00	Hospital			N		N		N		N	155.00	
156.00	Subprovider - IPF			N		N		N		N	156.00	
157.00	Subprovider - IRF			N		N		N		N	157.00	
158.00	SUBPROVIDER										158.00	
159.00	SNF			N		N		N		N	159.00	
160.00	HOME HEALTH AGENCY			N		N		N		N	160.00	
161.00	CMHC					N		N		N	161.00	
									1.00			
Multicampus												
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00		
		Name		County		State		Zip Code		CBSA	FTE/Campus	
		0		1.00		2.00		3.00		4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)										0.00	166.00
									1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act												
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								N	167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00		
								Beginning	Ending			
								1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00		
								1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4039		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 10/15/2020 3:52 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
10/15/2020 3:52 pm

Description		Y/N	Y/N	
0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N	20.00
		Y/N	Date	
		1.00	2.00	
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	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2019	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MONIQUECA	SUGGS	41.00
42.00	Enter the employer/company name of the cost report preparer	UNIVERSAL HEALTH SERVICES, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	629-208-5503	MONIQUECA.SUGGS@UHSINC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 10/15/2020 3:52 pm
		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 ANALYST		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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,120	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)		88	32,120	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)		88	32,120	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		88			0	27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	5,627	14,891			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	5,627	14,891			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	5,627	14,891	0.00	124.45	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	124.45	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	0	274	1,071	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	274	1,071	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
10/15/2020 3:52 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		919,865	919,865	0	919,865	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		164,251	164,251	7,959	172,210	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	183,590	2,083,168	2,266,758	0	2,266,758	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,072,503	1,783,359	3,855,862	-82,511	3,773,351	5.00
7.00	00700	OPERATION OF PLANT	138,798	492,458	631,256	0	631,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,281	109,281	0	109,281	8.00
9.00	00900	HOUSEKEEPING	0	180,969	180,969	0	180,969	9.00
10.00	01000	DIETARY	171,818	276,719	448,537	-1,400	447,137	10.00
13.00	01300	NURSING ADMINISTRATION	587,129	14,307	601,436	0	601,436	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	72,365	62,754	135,119	0	135,119	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,362,443	1,608,580	4,971,023	-70,471	4,900,552	30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	95,671	95,671	0	95,671	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	367,142	367,142	0	367,142	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	378,511	1,233	379,744	70,471	450,215	93.99
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,967,157	8,159,757	15,126,914	-75,952	15,050,962	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	75,952	75,952	194.00
194.01	07951	EDUCATION	61,113	593	61,706	0	61,706	194.01
194.02	07953	PHP MEALS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	7,028,270	8,160,350	15,188,620	0	15,188,620	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	919,865	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	172,210	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-147,040	2,119,718	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-824,432	2,948,919	5.00
7.00	00700	OPERATION OF PLANT	0	631,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,281	8.00
9.00	00900	HOUSEKEEPING	0	180,969	9.00
10.00	01000	DIETARY	0	447,137	10.00
13.00	01300	NURSING ADMINISTRATION	0	601,436	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	135,119	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,142,548	3,758,004	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	95,671	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	367,142	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	450,215	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,114,020	12,936,942	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MARKETING	0	75,952	194.00
194.01	07951	EDUCATION	0	61,706	194.01
194.02	07953	PHP MEALS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,114,020	13,074,600	200.00

RECLASSIFICATIONS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
10/15/2020 3:52 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,959	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	7,959	
	B - MARKETING				
1.00	MARKETING	194.00	108,452	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	32,500	2.00
	TOTALS		108,452	32,500	
	C - PSYCH TESTING				
1.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	48,204	22,267	1.00
	TOTALS		48,204	22,267	
500.00	Grand Total: Increases		156,656	62,726	500.00

RECLASSIFICATIONS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RENT LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,559	10	1.00
2.00	DIETARY	10.00	0	1,400	10	2.00
	TOTALS		0	7,959		
B - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	108,452	0	0	1.00
2.00	MARKETING	194.00	0	32,500	0	2.00
	TOTALS		108,452	32,500		
C - PSYCH TESTING						
1.00	ADULTS & PEDIATRICS	30.00	48,204	22,267	0	1.00
	TOTALS		48,204	22,267		
500.00	Grand Total: Decreases		156,656	62,726		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	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	0	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)	1	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)	1	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	1	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	1	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	1	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	488,150	0	0	25,292	406,423	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	158,311	0	0	5,940	0	2.00
3.00	Total (sum of lines 1-2)	646,461	0	0	31,232	406,423	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	919,865				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	164,251				2.00
3.00	Total (sum of lines 1-2)	0	1,084,116				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	488,150	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	158,311	7,959	2.00
3.00	Total (sum of lines 1-2)	0	0	0	646,461	7,959	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	25,292	406,423	0	919,865	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,940	0	0	172,210	2.00
3.00	Total (sum of lines 1-2)	0	31,232	406,423	0	1,092,075	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	-28,045	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	-1,149,795			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	-110,166			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests			0	0.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	MISC ADMIN	B	-14,153	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	BAD DEBT	A	-442,341	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN BILLING COST	A	-24,992	ADMINISTRATIVE & GENERAL	5.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.03	REBATES	A	28,045	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	SPORTS SEASON TICKETS	A	-19,470	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PART B PHYSICIAN COST	A	7,247	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	MALPRACTICE	A	-8,030	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DONATIONS	A	4,796	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING	A	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PATIENT TRANSPORTATION	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	PATIENT TRANSPORTATION	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	12	33.10
33.11	PATIENT TRANSPORTATION	A	-42,855	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PATIENT TRANSPORTATION	A	-237,764	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	EMPLOYED PHYSICIAN BENEFITS	A	-62,885	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	LEGAL FEES	A	-13,112	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,114,020				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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
10/15/2020 3:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	669,656	679,442	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP INS	44,962	86,262	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	0	59,080	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			714,618	824,784	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	Name	Percentage of Ownership	
	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	UHS, INC	100.00	UHS, INC	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
10/15/2020 3:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	-9,786	0		2.00
3.00	-41,300	0		3.00
4.00	-59,080	0		4.00
5.00	-110,166			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	HOSPITAL MGMT		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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
10/15/2020 3:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,149,795	1,149,795	0	181,300	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			1,149,795	1,149,795	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,149,795		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	1,149,795		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	919,865	919,865				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	172,210		172,210			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,119,718	0	0	2,119,718		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,948,919	93,319	17,470	608,243	3,667,951	5.00
7.00	00700	OPERATION OF PLANT	631,256	144,504	27,053	42,984	845,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,281	6,643	1,244	0	117,168	8.00
9.00	00900	HOUSEKEEPING	180,969	5,267	986	0	187,222	9.00
10.00	01000	DIETARY	447,137	69,757	13,059	53,210	583,163	10.00
13.00	01300	NURSING ADMINISTRATION	601,436	12,512	2,342	181,827	798,117	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	135,119	10,791	2,020	22,411	170,341	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,758,004	533,408	99,861	1,026,382	5,417,655	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	95,671	2,444	458	0	98,573	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,142	8,020	1,502	0	376,664	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	450,215	22,271	4,169	132,149	608,804	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,936,942	908,936	170,164	2,067,206	12,871,455	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	75,952	0	0	33,586	109,538	194.00
194.01	07951	EDUCATION	61,706	10,929	2,046	18,926	93,607	194.01
194.02	07953	PHP MEALS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,074,600	919,865	172,210	2,119,718	13,074,600	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,667,951				5.00
7.00	00700	OPERATION OF PLANT	329,803	1,175,600			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,688	11,451	174,307		8.00
9.00	00900	HOUSEKEEPING	73,004	9,078	0	269,304	9.00
10.00	01000	DIETARY	227,394	120,236	0	28,033	10.00
13.00	01300	NURSING ADMINISTRATION	311,211	21,567	0	5,028	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,421	18,601	0	4,337	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,112,516	919,404	174,307	214,359	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	38,437	4,213	0	982	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,873	13,824	0	3,223	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	237,392	38,388	0	8,950	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,588,739	1,156,762	174,307	264,912	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	MARKETING	42,712	0	0	0	194.00
194.01	07951	EDUCATION	36,500	18,838	0	4,392	194.01
194.02	07953	PHP MEALS	0	0	0	216,643	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,667,951	1,175,600	174,307	269,304	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATION	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	1,135,923					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	259,700				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,135,923	218,674	10,935,021	0	10,935,021	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	1,554	143,759	0	143,759	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,693	546,277	0	546,277	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	33,779	927,313	0	927,313	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,135,923	259,700	12,552,370	0	12,552,370	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	152,250	0	152,250	194.00
194.01	07951	EDUCATION	0	0	153,337	0	153,337	194.01
194.02	07953	PHP MEALS	0	0	216,643	0	216,643	194.02
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)	1,135,923	259,700	13,074,600	0	13,074,600	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4039

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,755	93,319	17,470	130,544	0 5.00
7.00	00700	OPERATION OF PLANT	0	144,504	27,053	171,557	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,643	1,244	7,887	0 8.00
9.00	00900	HOUSEKEEPING	0	5,267	986	6,253	0 9.00
10.00	01000	DIETARY	0	69,757	13,059	82,816	0 10.00
13.00	01300	NURSING ADMINISTRATION	0	12,512	2,342	14,854	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,791	2,020	12,811	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	533,408	99,861	633,269	0 30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	2,444	458	2,902	0 60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,020	1,502	9,522	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	22,271	4,169	26,440	0 93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,755	908,936	170,164	1,098,855	0 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	MARKETING	0	0	0	0	0 194.00
194.01	07951	EDUCATION	0	10,929	2,046	12,975	0 194.01
194.02	07953	PHP MEALS	0	0	0	0	0 194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	19,755	919,865	172,210	1,111,830	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	130,544					5.00
7.00	00700	OPERATION OF PLANT	11,738	183,295				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,626	1,785	11,298			8.00
9.00	00900	HOUSEKEEPING	2,598	1,415	0	10,266		9.00
10.00	01000	DIETARY	8,093	18,747	0	1,069	110,725	10.00
13.00	01300	NURSING ADMINISTRATION	11,076	3,363	0	192	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,364	2,900	0	165	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	75,186	143,351	11,298	8,172	85,707	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	1,368	657	0	37	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,227	2,155	0	123	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	8,449	5,985	0	341	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,725	180,358	11,298	10,099	85,707	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	1,520	0	0	0	0	194.00
194.01	07951	EDUCATION	1,299	2,937	0	167	0	194.01
194.02	07953	PHP MEALS	0	0	0	0	25,018	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,544	183,295	11,298	10,266	110,725	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			NURSING ADMINISTRATION	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	29,485					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,240				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,485	15,357	1,001,825	0	1,001,825	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	109	5,073	0	5,073	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	400	17,427	0	17,427	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	2,374	43,589	0	43,589	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,485	18,240	1,067,914	0	1,067,914	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	1,520	0	1,520	194.00
194.01	07951	EDUCATION	0	0	17,378	0	17,378	194.01
194.02	07953	PHP MEALS	0	0	25,018	0	25,018	194.02
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)	29,485	18,240	1,111,830	0	1,111,830	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	53,446					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		53,446				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,844,680			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,422	5,422	1,964,051	-3,667,951	9,406,649	5.00
7.00	00700	OPERATION OF PLANT	8,396	8,396	138,798	0	845,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	386	386	0	0	117,168	8.00
9.00	00900	HOUSEKEEPING	306	306	0	0	187,222	9.00
10.00	01000	DIETARY	4,053	4,053	171,818	0	583,163	10.00
13.00	01300	NURSING ADMINISTRATION	727	727	587,129	0	798,117	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	627	627	72,365	0	170,341	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,992	30,992	3,314,239	0	5,417,655	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	142	142	0	0	98,573	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466	466	0	0	376,664	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,294	1,294	426,715	0	608,804	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,811	52,811	6,675,115	-3,667,951	9,203,504	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	108,452	0	109,538	194.00
194.01	07951	EDUCATION	635	635	61,113	0	93,607	194.01
194.02	07953	PHP MEALS	0	0	0	0	0	194.02
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)	919,865	172,210	2,119,718		3,667,951	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.211110	3.222131	0.309688		0.389932	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		130,544	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.013878	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT 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	39,628				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	386	14,891			8.00
9.00	00900	HOUSEKEEPING	306	0	38,936		9.00
10.00	01000	DIETARY	4,053	0	4,053	57,713	10.00
13.00	01300	NURSING ADMINISTRATION	727	0	727	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	627	0	627	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,992	14,891	30,992	44,673	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	142	0	142	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466	0	466	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,294	0	1,294	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,993	14,891	38,301	44,673	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	EDUCATION	635	0	635	0	194.01
194.02	07953	PHP MEALS	0	0	0	13,040	194.02
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)	1,175,600	174,307	269,304	958,826	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.665893	11.705527	6.916581	16.613692	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	183,295	11,298	10,266	110,725	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.625391	0.758713	0.263663	1.918545	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS 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
		25,814,712	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		21,736,480	
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		565,948	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
		3,357,800	
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
		25,814,712	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	EDUCATION	194.01
194.02	07953	PHP MEALS	194.02
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
		259,700	
203.00	Unit cost multiplier (Wkst. B, Part I)		203.00
		0.010060	
204.00	Cost to be allocated (per Wkst. B, Part II)		204.00
		18,240	
205.00	Unit cost multiplier (Wkst. B, Part II)		205.00
		0.000707	
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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

				Title XVIII		Hospital		PPS		
Cost Center Description				Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
						Total Costs	RCE Disallowance		Total Costs	
				1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	10,935,021			10,935,021	0	10,935,021	30.00	
ANCILLARY SERVICE COST CENTERS										
60.00	06000	LABORATORY	143,759			143,759	0	143,759	60.00	
69.00	06900	ELECTROCARDIOLOGY	0			0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0			0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	546,277			546,277	0	546,277	73.00	
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0			0	0	0	90.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	927,313			927,313	0	927,313	93.99	
200.00		Subtotal (see instructions)	12,552,370	0		12,552,370	0	12,552,370	200.00	
201.00		Less Observation Beds	0			0	0	0	201.00	
202.00		Total (see instructions)	12,552,370	0		12,552,370	0	12,552,370	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,736,480		21,736,480			30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	154,484	0	154,484	0.930575	0.000000	60.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	565,948	0	565,948	0.965242	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	3,357,800	3,357,800	0.276167	0.000000	93.99
200.00		Subtotal (see instructions)	22,456,912	3,357,800	25,814,712			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,456,912	3,357,800	25,814,712			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 10/15/2020 3:52 pm
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0.930575			60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.965242			73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.276167			93.99
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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

				Title XIX		Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,935,021		10,935,021	0	10,935,021	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	143,759		143,759	0	143,759	60.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546,277		546,277	0	546,277	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	927,313		927,313	0	927,313	93.99
200.00		Subtotal (see instructions)	12,552,370	0	12,552,370	0	12,552,370	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	12,552,370	0	12,552,370	0	12,552,370	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,736,480		21,736,480				30.00
	ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	154,484	0	154,484	0.930575	0.000000		60.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	565,948	0	565,948	0.965242	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	3,357,800	3,357,800	0.276167	0.000000		93.99
200.00		Subtotal (see instructions)	22,456,912	3,357,800	25,814,712				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	22,456,912	3,357,800	25,814,712				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,001,825	0	1,001,825	14,891	67.28	30.00
200.00	Total (lines 30 through 199)		1,001,825		1,001,825	14,891		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		0	0				
200.00	Total (lines 30 through 199)		0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	5,073	154,484	0.032838	0	0 60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,427	565,948	0.030793	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	43,589	3,357,800	0.012981	0	0 93.99
200.00		Total (lines 50 through 199)	66,089	4,078,232		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-4039		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 10/15/2020 3:52 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	14,891	0.00	0	0	30.00
200.00		Total (lines 30 through 199)			0	14,891		0	0	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-4039		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 10/15/2020 3:52 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	154,484	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	565,948	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	3,357,800	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	4,078,232		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 10/15/2020 3:52 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,891	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,891	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)		14,891	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)		0	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)		10,935,021	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)		10,935,021	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)		10,935,021	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)		734.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
10/15/2020 3:52 pm

		Title XVIII		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(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)					0	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,001,825	10,935,021	0.091616	0	0	90.00
91.00	Nursing School cost	0	10,935,021	0.000000	0	0	91.00
92.00	Allied health cost	0	10,935,021	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,935,021	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 10/15/2020 3:52 pm
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			14,891 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,891 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)			14,891 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)			5,627 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)			10,935,021 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)			10,935,021 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)			10,935,021 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)			734.34 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,132,131 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			4,132,131 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					260,854	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,392,985	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,001,825	10,935,021	0.091616	0	0	90.00
91.00	Nursing School cost	0	10,935,021	0.000000	0	0	91.00
92.00	Allied health cost	0	10,935,021	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,935,021	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 10/15/2020 3:52 pm	
		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		8,217,012	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0.930575	58,399	54,345 60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.965242	213,945	206,509 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.276167	0	0 93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		272,344	260,854 200.00
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)		272,344	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4039	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 10/15/2020 3:52 pm
		Title XVIII	Hospital	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		0	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		40.685792	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		0	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		0	18.00
19.00	Deductibles		0	19.00
20.00	Subtotal (line 18 minus line 19)		0	20.00
21.00	Coinurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		0	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		0	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		0	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet E-3
Part VII
Date/Time Prepared:
10/15/2020 3:52 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,392,985		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)		4,392,985	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)		4,392,985	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		8,489,356		8.00
9.00	Ancillary service charges		272,344	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)		8,761,700	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)		8,761,700	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,368,715	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)		4,392,985	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	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,392,985	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)		4,392,985	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,392,985	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,392,985	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)		4,392,985	0	40.00
41.00	Interim payments		7,798,634	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-3,405,649	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: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
10/15/2020 3:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-144,383	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	3,555,502	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	68,096	0	0	0	7.00
8.00	Prepaid expenses	16,709	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)	3,495,924	0	0	0	11.00
FIXED ASSETS						
12.00	Land	50,000	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	17,194,514	0	0	0	15.00
16.00	Accumulated depreciation	-3,193,830	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	1,581,346	0	0	0	23.00
24.00	Accumulated depreciation	-1,168,216	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,463,814	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	2,737	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,737	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,962,475	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	255,773	0	0	0	37.00
38.00	Salaries, wages, and fees payable	980,091	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	16,770,455	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)	18,006,319	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	-5,644,667	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)	-5,644,667	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,361,652	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,600,823				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,600,823	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,962,475	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
10/15/2020 3:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		676,102		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,924,724				2.00
3.00	Total (sum of line 1 and line 2)		5,600,826		0		3.00
4.00	ROUNDING	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)		5,600,826		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,600,823		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	ROUNDING		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: 14-4039

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
10/15/2020 3:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	21,736,480		21,736,480	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	21,736,480		21,736,480	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)	21,736,480		21,736,480	17.00
18.00	Ancillary services	720,432	0	720,432	18.00
19.00	Outpatient services	0	3,357,800	3,357,800	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	22,456,912	3,357,800	25,814,712	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,188,620		29.00
30.00	PROVIDER TAXES	1,803,809			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)		1,803,809		36.00
37.00	PHYSICIAN REVENUE	2,360,516			37.00
38.00	BAD DEBTS	442,340			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)		2,802,856		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,189,573		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4039

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
10/15/2020 3:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	25,814,712	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,769,578	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,045,134	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,189,573	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,855,561	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	MISC	69,163	24.00
25.00	Total other income (sum of lines 6-24)	69,163	25.00
26.00	Total (line 5 plus line 25)	4,924,724	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,924,724	29.00