

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/22/2022 9:07 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (14-1322) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Kathryn Keim	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Kathryn Keim		2
3	Signatory Title	SENIOR VICE PRESIDENT & CFO		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-42,456	144,499	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	178,899	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	136,443	144,499	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1322		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:07 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 200 STAHLHUT DRIVE			PO Box:				1.00		
2.00	City: LINCOLN			State: IL		Zip Code: 62656		County: LOGAN		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		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		ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2020	09/30/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/22/2022 9:07 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1322		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:07 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/22/2022 9:07 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:07 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
			V 1.00	XIX 2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:07 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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:	53,535	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1322		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:07 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: MEMORIAL HELATH SYSTEM	Contractor's Name: NGS		Contractor's Number: 00131						
142.00	Street: 701 NORTH FIRST STREET	PO Box:								
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62781						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	N	157.00			
158.00	SUBPROVIDER						158.00			
159.00	SNF	N	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00			
161.00	CMHC		N	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			
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/22/2022 9:07 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/02/2022	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/22/2022 9:07 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/22/2022 9:07 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SIGNING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	70,353.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	70,353.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	70,353.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,263	97	2,592			1.00
2.00	HMO and other (see instructions)	398	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,622	0	2,302			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	336			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,885	97	5,230			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		38	265			13.00
14.00	Total (see instructions)	2,885	135	5,495	0.00	267.86	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	267.86	27.00
28.00	Observation Bed Days		5	415			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			44			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	64			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	298	37	926	1.00
2.00 HMO and other (see instructions)			80	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	298	37	926	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/22/2022 9:07 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.271018		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		9,120,261		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		34,864,745		6.00
7.00	Medicaid cost (line 1 times line 6)		9,448,973		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		328,712		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		62,797		9.00
10.00	Stand-alone CHIP charges		216,624		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		58,709		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		328,712		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	589,133	238,517	827,650	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	159,666	238,517	398,183	21.00
22.00	Payments received from patients for amounts previously written off as charity care	4,058	0	4,058	22.00
23.00	Cost of charity care (line 21 minus line 22)	155,608	238,517	394,125	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,243,744	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			760,228	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,169,582	27.01
28.00	Non-Medicare bad debt expense (see instructions)			74,162	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			429,453	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			823,578	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,152,290	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1322

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

Worksheet A

Date/Time Prepared:
2/22/2022 9:07 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,160,234	2,160,234	20,757	2,180,991	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,044,929	1,044,929	7,358	1,052,287	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	829,347	4,228,877	5,058,224	-83,190	4,975,034	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,440,187	6,499,410	8,939,597	-28,160	8,911,437	5.00
7.00	00700	OPERATION OF PLANT	646,278	859,726	1,506,004	0	1,506,004	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	241,981	241,981	8.00
9.00	00900	HOUSEKEEPING	400,147	359,727	759,874	-241,981	517,893	9.00
10.00	01000	DIETARY	664,637	397,074	1,061,711	-732,553	329,158	10.00
11.00	01100	CAFETERIA	0	0	0	718,836	718,836	11.00
13.00	01300	NURSING ADMINISTRATION	442,554	167,166	609,720	-252,701	357,019	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,747	214,513	357,260	-148,668	208,592	14.00
15.00	01500	PHARMACY	489,555	1,780,605	2,270,160	-1,749,005	521,155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	602,880	32,867	635,747	0	635,747	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	252,701	252,701	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,002,316	0	1,002,316	83,190	1,085,506	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,058,245	2,375,402	4,433,647	750,667	5,184,314	30.00
43.00	04300	NURSERY	0	4,228	4,228	137,969	142,197	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	941,895	1,029,920	1,971,815	-146,589	1,825,226	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	921,216	324,408	1,245,624	-889,710	355,914	52.00
53.00	05300	ANESTHESIOLOGY	0	118,325	118,325	0	118,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,601,231	705,492	2,306,723	-20,816	2,285,907	54.00
60.00	06000	LABORATORY	978,269	1,494,220	2,472,489	-15,998	2,456,491	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	459,207	24,525	483,732	0	483,732	65.00
66.00	06600	PHYSICAL THERAPY	1,338,356	45,074	1,383,430	0	1,383,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,674	885	188,559	0	188,559	67.00
68.00	06800	SPEECH PATHOLOGY	68,616	296	68,912	0	68,912	68.00
69.00	06900	ELECTROCARDIOLOGY	243,180	160,147	403,327	0	403,327	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	173,859	173,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	123,256	123,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,788,392	1,788,392	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	189,135	89,903	279,038	0	279,038	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	12,450	12,450	76.01
76.97	07697	CARDIAC REHABILITATION	178,838	12,716	191,554	0	191,554	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,674,881	3,716,384	5,391,265	-2,045	5,389,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,501,391	27,847,053	46,348,444	0	46,348,444	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	18,501,391	27,847,053	46,348,444	0	46,348,444	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1322

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

Worksheet A

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	43,122	2,224,113	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	215,355	1,267,642	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-324,445	4,650,589	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,055,950	7,855,487	5.00
7.00	00700	OPERATION OF PLANT	0	1,506,004	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	241,981	8.00
9.00	00900	HOUSEKEEPING	0	517,893	9.00
10.00	01000	DIETARY	0	329,158	10.00
11.00	01100	CAFETERIA	-122,162	596,674	11.00
13.00	01300	NURSING ADMINISTRATION	0	357,019	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	208,592	14.00
15.00	01500	PHARMACY	0	521,155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,610	632,137	16.00
17.00	01700	SOCIAL SERVICE	0	252,701	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,085,506	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,421,841	3,762,473	30.00
43.00	04300	NURSERY	0	142,197	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,825,226	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-154,834	201,080	52.00
53.00	05300	ANESTHESIOLOGY	-91,576	26,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,285,907	54.00
60.00	06000	LABORATORY	-2,182	2,454,309	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	483,732	65.00
66.00	06600	PHYSICAL THERAPY	0	1,383,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	188,559	67.00
68.00	06800	SPEECH PATHOLOGY	0	68,912	68.00
69.00	06900	ELECTROCARDIOLOGY	-134,524	268,803	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	173,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	123,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,788,392	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	279,038	76.00
76.01	03950	DIABETIC EDUCATION	0	12,450	76.01
76.97	07697	CARDIAC REHABILITATION	0	191,554	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,525,794	2,863,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,663,947	39,684,497	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,663,947	39,684,497	200.00

RECLASSIFICATIONS

Provider CCN: 14-1322

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

Worksheet A-6

Date/Time Prepared:
2/22/2022 9:07 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	634,122	116,727		1.00
2.00	NURSERY	43.00	116,520	21,449		2.00
			750,642	138,176		
	C - CASE MANAGEMENT					
1.00	SOCIAL SERVICE	17.00	252,701	0		1.00
			252,701	0		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	28,115		1.00
			0	28,115		
	E - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,788,392		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
			0	1,788,392		
	F - LAUNDRY EXPENSE					
1.00	LAUNDRY & LINEN SERVICE	8.00	28,565	213,416		1.00
			28,565	213,416		
	G - IMPLANTS & MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	173,859		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	123,256		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
			0	297,115		
	H - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	446,825	272,011		1.00
2.00	DIABETIC EDUCATION	76.01	12,450	0		2.00
			459,275	272,011		
	K - CRNA BENEFITS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	83,190		1.00
			0	83,190		
500.00	Grand Total: Increases		1,491,183	2,820,415		500.00

RECLASSIFICATIONS

Provider CCN: 14-1322

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

Worksheet A-6

Date/Time Prepared:
2/22/2022 9:07 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	750,642	138,176	0		1.00
2.00		0.00	0	0	0		2.00
			750,642	138,176			
	C - CASE MANAGEMENT						
1.00	NURSING ADMINISTRATION	13.00	252,701	0	0		1.00
			252,701	0			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,115	12		1.00
			0	28,115			
	E - DRUG EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45	0		1.00
2.00	DIETARY	10.00	0	1,267	0		2.00
3.00	PHARMACY	15.00	0	1,748,918	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,563	0		4.00
5.00	LABORATORY	60.00	0	15,998	0		5.00
6.00	EMERGENCY	91.00	0	1,601	0		6.00
			0	1,788,392			
	F - LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	28,565	213,416	0		1.00
			28,565	213,416			
	G - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	148,668	0		1.00
2.00	PHARMACY	15.00	0	87	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	182	0		3.00
4.00	OPERATING ROOM	50.00	0	146,589	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	892	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	253	0		6.00
7.00	EMERGENCY	91.00	0	444	0		7.00
			0	297,115			
	H - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	459,275	272,011	0		1.00
2.00		0.00	0	0	0		2.00
			459,275	272,011			
	K - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	83,190	0		1.00
			0	83,190			
500.00	Grand Total: Decreases		1,491,183	2,820,415			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/22/2022 9:07 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,421,216	0	0	0	0	1.00	
2.00	Land Improvements	6,078,200	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	44,650,230	0	0	0	0	4.00	
5.00	Fixed Equipment	0	254,983	0	254,983	0	5.00	
6.00	Movable Equipment	18,424,573	669,035	0	669,035	517,637	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	70,574,219	924,018	0	924,018	517,637	8.00	
9.00	Reconciling Items	-247,095	-1,670,130	0	-1,670,130	-604,167	9.00	
10.00	Total (line 8 minus line 9)	70,821,314	2,594,148	0	2,594,148	1,121,804	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,421,216	0				1.00	
2.00	Land Improvements	6,078,200	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	44,650,230	0				4.00	
5.00	Fixed Equipment	254,983	0				5.00	
6.00	Movable Equipment	18,575,971	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	70,980,600	0				8.00	
9.00	Reconciling Items	-1,313,058	0				9.00	
10.00	Total (line 8 minus line 9)	72,293,658	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,160,234	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,044,929	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,205,163	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,160,234				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,044,929				2.00
3.00	Total (sum of lines 1-2)	0	3,205,163				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	52,404,629	0	52,404,629	0.738295	20,757	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,575,971	0	18,575,971	0.261705	7,358	2.00
3.00	Total (sum of lines 1-2)	70,980,600	0	70,980,600	1.000000	28,115	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	20,757	2,203,356	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	7,358	1,260,284	0	2.00
3.00	Total (sum of lines 1-2)	0	0	28,115	3,463,640	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	20,757	0	0	2,224,113	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,358	0	0	1,267,642	2.00
3.00	Total (sum of lines 1-2)	0	28,115	0	0	3,491,755	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1322

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

Worksheet A-8

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-10,575	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-44	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,241	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-17,406	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,328,569			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	567,775			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-122,162	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,610	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,085,506	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-30,615	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INCOME - A&G	B	-51,017	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1322

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

Worksheet A-8

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	RENTAL INCOME	B	-8,942	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INCOME - LAB	B	-2,182	LABORATORY	60.00	0	33.02
34.00	PROVIDER TAX	A	-1,737,813	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MARKETING - SALARIES	A	-46,017	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	MARKETING - BENEFITS	A	-11,263	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.01
35.02	MARKETING - OTHER	A	-25,322	ADMINISTRATIVE & GENERAL	5.00	0	35.02
36.00	FUNDED DEPRECIATION TRUSTEE FEES	A	22,516	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MUTUAL FUND FEES	A	263,286	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	LOBBYING EXPENSE	A	-19,780	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	PHYSICIAN LOAN FORGIVENESS	A	-13,460	ADMINISTRATIVE & GENERAL	5.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,663,947				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-1322

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

Worksheet A-8-1

Date/Time Prepared:
2/22/2022 9:07 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	38,929	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	63,682	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	4,193	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	182,288	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	10,575	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,420,666	1,839,376	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE BENEFITS	2,173,740	2,486,922	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	467,488	467,488	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,361,561	4,793,786	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1322

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

Worksheet A-8-1

Date/Time Prepared:
2/22/2022 9:07 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	38,929	9		1.00
2.00	63,682	9		2.00
3.00	4,193	9		3.00
4.00	182,288	9		4.00
4.01	10,575	0		4.01
4.02	581,290	0		4.02
4.03	-313,182	0		4.03
4.04	0	0		4.04
5.00	567,775			5.00

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

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

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

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

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

6.00	MANAGEMENT/HO		6.00
7.00	HOSPITAL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1322

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

Worksheet A-8-2

Date/Time Prepared:
2/22/2022 9:07 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,421,841	1,421,841	0	0	0	1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	154,834	154,834	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	91,576	91,576	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	134,524	134,524	0	0	0	4.00
5.00	91.00	EMERGENCY	2,930,743	2,525,794	404,949	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			4,733,518	4,328,569	404,949		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	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	1,421,841		1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	154,834		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	91,576		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	134,524		4.00
5.00	91.00	EMERGENCY	0	0	0	2,525,794		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	4,328,569		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,224,113	2,224,113				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,267,642		1,267,642			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,650,589	2,028	0	4,652,617		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,855,487	135,850	432,529	670,076	9,093,942	5.00
7.00	00700	OPERATION OF PLANT	1,506,004	778,429	41,956	180,879	2,507,268	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	241,981	9,931	0	7,995	259,907	8.00
9.00	00900	HOUSEKEEPING	517,893	55,550	2,195	103,998	679,636	9.00
10.00	01000	DIETARY	329,158	42,187	7,747	57,476	436,568	10.00
11.00	01100	CAFETERIA	596,674	42,533	16,856	125,056	781,119	11.00
13.00	01300	NURSING ADMINISTRATION	357,019	6,448	508	53,136	417,111	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	208,592	40,956	0	39,952	289,500	14.00
15.00	01500	PHARMACY	521,155	24,750	10,593	137,016	693,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	632,137	30,020	1,203	168,733	832,093	16.00
17.00	01700	SOCIAL SERVICE	252,701	0	0	70,725	323,426	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,762,473	315,066	112,321	753,540	4,943,400	30.00
43.00	04300	NURSERY	142,197	6,448	10,764	32,611	192,020	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,825,226	181,590	227,253	263,616	2,497,685	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	201,080	13,294	15,757	47,740	277,871	52.00
53.00	05300	ANESTHESIOLOGY	26,749	5,269	4,223	0	36,241	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,285,907	130,096	187,658	448,149	3,051,810	54.00
60.00	06000	LABORATORY	2,454,309	78,151	57,845	273,796	2,864,101	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	483,732	15,668	10,555	128,522	638,477	65.00
66.00	06600	PHYSICAL THERAPY	1,383,430	87,909	18,914	374,576	1,864,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	188,559	0	0	52,526	241,085	67.00
68.00	06800	SPEECH PATHOLOGY	68,912	1,872	0	19,204	89,988	68.00
69.00	06900	ELECTROCARDIOLOGY	268,803	3,102	56,813	68,061	396,779	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	173,859	0	0	0	173,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,256	0	0	0	123,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,788,392	0	0	0	1,788,392	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	279,038	29,136	0	52,935	361,109	76.00
76.01	03950	DIABETIC EDUCATION	12,450	0	0	3,484	15,934	76.01
76.97	07697	CARDIAC REHABILITATION	191,554	67,856	16,273	50,053	325,736	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,863,426	103,942	35,679	468,762	3,471,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,684,497	2,208,081	1,267,642	4,652,617	39,668,465	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,032	0	0	16,032	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,684,497	2,224,113	1,267,642	4,652,617	39,684,497	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,093,942				5.00
7.00	00700	OPERATION OF PLANT	745,358	3,252,626			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,265	24,700	361,872		8.00
9.00	00900	HOUSEKEEPING	202,042	138,157	0	1,019,835	9.00
10.00	01000	DIETARY	129,782	104,922	838	34,631	706,741 10.00
11.00	01100	CAFETERIA	232,210	105,784	1,825	34,916	0 11.00
13.00	01300	NURSING ADMINISTRATION	123,998	16,036	0	5,293	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,062	101,861	0	33,621	0 14.00
15.00	01500	PHARMACY	206,167	61,557	0	20,318	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	247,364	74,661	0	24,643	0 16.00
17.00	01700	SOCIAL SERVICE	96,148	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,469,581	783,595	120,003	258,641	657,894 30.00
43.00	04300	NURSERY	57,084	16,036	1,868	5,293	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	742,509	451,630	38,818	149,069	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82,605	33,063	2,736	10,913	0 52.00
53.00	05300	ANESTHESIOLOGY	10,774	13,104	0	4,325	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	907,239	323,560	51,322	106,797	0 54.00
60.00	06000	LABORATORY	851,437	194,369	13	64,155	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	189,806	38,969	0	12,862	0 65.00
66.00	06600	PHYSICAL THERAPY	554,375	218,638	31,013	72,165	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	71,670	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	26,752	4,656	0	1,537	0 68.00
69.00	06900	ELECTROCARDIOLOGY	117,954	7,716	10,809	2,547	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,685	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,641	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	531,651	0	0	0	0 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	107,350	72,463	0	23,918	0 76.00
76.01	03950	DIABETIC EDUCATION	4,737	0	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	96,834	168,763	0	55,703	0 76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,032,096	258,512	93,118	85,327	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,089,176	3,212,752	352,363	1,006,674	657,894 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,766	39,874	0	13,161	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,509	0	48,847 192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	9,093,942	3,252,626	361,872	1,019,835	706,741 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,155,854					11.00
13.00	01300	NURSING ADMINISTRATION	12,545	574,983				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,286	0	531,330			14.00
15.00	01500	PHARMACY	34,344	0	2,892	1,018,792		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,272	0	45	0	1,254,078	16.00
17.00	01700	SOCIAL SERVICE	16,727	25,269	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	260,870	156,476	56,969	0	216,906	30.00
43.00	04300	NURSERY	8,452	24,378	1,244	0	27,186	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,364	144,649	151,591	0	143,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,456	35,689	506	0	12,278	52.00
53.00	05300	ANESTHESIOLOGY	22,688	31,287	5,520	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,973	0	26,944	0	106,699	54.00
60.00	06000	LABORATORY	113,886	0	154,870	0	111,376	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	41,818	0	2,658	0	22,509	65.00
66.00	06600	PHYSICAL THERAPY	104,811	0	5,343	0	8,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,261	0	72	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	4,716	0	63	0	2,631	68.00
69.00	06900	ELECTROCARDIOLOGY	20,286	0	2,157	0	21,924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	36,950	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	26,195	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,018,792	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	16,816	0	9	0	8,477	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	6,431	76.01
76.97	07697	CARDIAC REHABILITATION	15,214	0	1,004	0	2,046	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	143,069	157,235	56,298	0	544,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,155,854	574,983	531,330	1,018,792	1,236,246	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	17,832	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,155,854	574,983	531,330	1,018,792	1,254,078	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	461,570					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	461,570	0	9,385,905	-619,684	8,766,221	30.00
43.00	04300	NURSERY	0	0	333,561	0	333,561	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	4,398,847	0	4,398,847	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	468,117	0	468,117	52.00
53.00	05300	ANESTHESIOLOGY	0	0	123,939	0	123,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,709,344	0	4,709,344	54.00
60.00	06000	LABORATORY	0	0	4,354,207	0	4,354,207	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	618,898	618,898	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	947,099	0	947,099	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,859,651	0	2,859,651	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	331,257	0	331,257	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	130,343	0	130,343	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	580,172	0	580,172	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	262,494	0	262,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	186,092	0	186,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,338,835	0	3,338,835	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	590,142	0	590,142	76.00
76.01	03950	DIABETIC EDUCATION	0	0	27,102	0	27,102	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	665,300	0	665,300	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	5,842,069	786	5,842,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	461,570	0	39,534,476	0	39,534,476	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	73,833	0	73,833	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	76,188	0	76,188	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	461,570	0	39,684,497	0	39,684,497	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,028	0	2,028	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,380	135,850	432,529	583,759	5.00
7.00	00700	OPERATION OF PLANT	10,711	778,429	41,956	831,096	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,931	0	9,931	8.00
9.00	00900	HOUSEKEEPING	0	55,550	2,195	57,745	9.00
10.00	01000	DIETARY	0	42,187	7,747	49,934	10.00
11.00	01100	CAFETERIA	0	42,533	16,856	59,389	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,448	508	6,956	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,956	0	40,956	14.00
15.00	01500	PHARMACY	0	24,750	10,593	35,343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,020	1,203	31,223	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,483	315,066	112,321	451,870	30.00
43.00	04300	NURSERY	0	6,448	10,764	17,212	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	181,590	227,253	408,843	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,294	15,757	29,051	52.00
53.00	05300	ANESTHESIOLOGY	0	5,269	4,223	9,492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140	130,096	187,658	317,894	54.00
60.00	06000	LABORATORY	70	78,151	57,845	136,066	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	196	15,668	10,555	26,419	65.00
66.00	06600	PHYSICAL THERAPY	0	87,909	18,914	106,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,872	0	1,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,102	56,813	59,915	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,136	0	29,136	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	67,856	16,273	84,129	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	103,942	35,679	139,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,980	2,208,081	1,267,642	3,526,703	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,032	0	16,032	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	50,980	2,224,113	1,267,642	3,542,735	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	584,051					5.00
7.00	00700	OPERATION OF PLANT	47,871	879,046				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,962	6,675	21,571			8.00
9.00	00900	HOUSEKEEPING	12,976	37,338	0	108,104		9.00
10.00	01000	DIETARY	8,335	28,356	50	3,671	90,371	10.00
11.00	01100	CAFETERIA	14,914	28,589	109	3,701	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,964	4,334	0	561	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,527	27,529	0	3,564	0	14.00
15.00	01500	PHARMACY	13,241	16,636	0	2,154	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,887	20,178	0	2,612	0	16.00
17.00	01700	SOCIAL SERVICE	6,175	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,375	211,771	7,153	27,415	84,125	30.00
43.00	04300	NURSERY	3,666	4,334	111	561	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,688	122,056	2,314	15,802	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,305	8,936	163	1,157	0	52.00
53.00	05300	ANESTHESIOLOGY	692	3,542	0	458	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,268	87,444	3,059	11,321	0	54.00
60.00	06000	LABORATORY	54,684	52,530	1	6,801	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,190	10,532	0	1,363	0	65.00
66.00	06600	PHYSICAL THERAPY	35,605	59,088	1,849	7,650	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,603	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,718	1,258	0	163	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,576	2,085	644	270	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,319	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,353	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,146	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,895	19,584	0	2,535	0	76.00
76.01	03950	DIABETIC EDUCATION	304	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	6,219	45,610	0	5,905	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	66,287	69,865	5,551	9,045	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	583,745	868,270	21,004	106,709	84,125	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	306	10,776	0	1,395	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	567	0	6,246	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	584,051	879,046	21,571	108,104	90,371	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	106,757					11.00
13.00	01300	NURSING ADMINISTRATION	1,159	20,997				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,874	0	79,467			14.00
15.00	01500	PHARMACY	3,172	0	433	71,039		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,952	0	7	0	76,933	16.00
17.00	01700	SOCIAL SERVICE	1,545	923	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,094	5,714	8,520	0	13,306	30.00
43.00	04300	NURSERY	781	890	186	0	1,668	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,330	5,282	22,672	0	8,805	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,150	1,303	76	0	753	52.00
53.00	05300	ANESTHESIOLOGY	2,096	1,143	826	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,466	0	4,030	0	6,546	54.00
60.00	06000	LABORATORY	10,519	0	23,162	0	6,833	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,862	0	398	0	1,381	65.00
66.00	06600	PHYSICAL THERAPY	9,681	0	799	0	520	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,594	0	11	0	72	67.00
68.00	06800	SPEECH PATHOLOGY	436	0	9	0	161	68.00
69.00	06900	ELECTROCARDIOLOGY	1,874	0	323	0	1,345	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,526	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,918	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,039	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,553	0	1	0	520	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	395	76.01
76.97	07697	CARDIAC REHABILITATION	1,405	0	150	0	126	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	13,214	5,742	8,420	0	33,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,757	20,997	79,467	71,039	75,839	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,094	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	106,757	20,997	79,467	71,039	76,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	8,674					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,674		937,346	0	937,346	30.00
43.00	04300	NURSERY	0		29,423	0	29,423	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		640,907	0	640,907	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		47,915	0	47,915	52.00
53.00	05300	ANESTHESIOLOGY	0		18,249	0	18,249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		501,223	0	501,223	54.00
60.00	06000	LABORATORY	0		290,715	0	290,715	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		56,201	0	56,201	65.00
66.00	06600	PHYSICAL THERAPY	0		222,178	0	222,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		6,303	0	6,303	67.00
68.00	06800	SPEECH PATHOLOGY	0		5,625	0	5,625	68.00
69.00	06900	ELECTROCARDIOLOGY	0		74,062	0	74,062	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		8,845	0	8,845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		6,271	0	6,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		105,185	0	105,185	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		60,247	0	60,247	76.00
76.01	03950	DIABETIC EDUCATION	0		701	0	701	76.01
76.97	07697	CARDIAC REHABILITATION	0		143,566	0	143,566	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0		351,357	0	351,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,674	0	3,506,319	0	3,506,319	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		28,509	0	28,509	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		7,907	0	7,907	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,674	0	3,542,735	0	3,542,735	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1322

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	128,322					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,260,284				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	16,623,710			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,838	430,018	2,394,170	-9,093,942	30,590,555	5.00
7.00	00700	OPERATION OF PLANT	44,912	41,712	646,278	0	2,507,268	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	28,565	0	259,907	8.00
9.00	00900	HOUSEKEEPING	3,205	2,182	371,582	0	679,636	9.00
10.00	01000	DIETARY	2,434	7,702	205,362	0	436,568	10.00
11.00	01100	CAFETERIA	2,454	16,758	446,825	0	781,119	11.00
13.00	01300	NURSING ADMINISTRATION	372	505	189,853	0	417,111	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	0	142,747	0	289,500	14.00
15.00	01500	PHARMACY	1,428	10,532	489,555	0	693,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,732	1,196	602,880	0	832,093	16.00
17.00	01700	SOCIAL SERVICE	0	0	252,701	0	323,426	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,178	111,669	2,692,367	0	4,943,400	30.00
43.00	04300	NURSERY	372	10,702	116,520	0	192,020	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,477	225,934	941,895	0	2,497,685	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	767	15,666	170,573	0	277,871	52.00
53.00	05300	ANESTHESIOLOGY	304	4,198	0	0	36,241	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	186,569	1,601,231	0	3,051,810	54.00
60.00	06000	LABORATORY	4,509	57,509	978,269	0	2,864,101	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	10,494	459,207	0	638,477	65.00
66.00	06600	PHYSICAL THERAPY	5,072	18,804	1,338,356	0	1,864,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	187,674	0	241,085	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	68,616	0	89,988	68.00
69.00	06900	ELECTROCARDIOLOGY	179	56,483	243,180	0	396,779	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	173,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	123,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,788,392	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,681	0	189,135	0	361,109	76.00
76.01	03950	DIABETIC EDUCATION	0	0	12,450	0	15,934	76.01
76.97	07697	CARDIAC REHABILITATION	3,915	16,179	178,838	0	325,736	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,997	35,472	1,674,881	0	3,471,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,397	1,260,284	16,623,710	-9,093,942	30,574,523	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	16,032	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,224,113	1,267,642	4,652,617		9,093,942	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.332281	1.005838	0.279878		0.297279	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,028		584,051	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000122		0.019093	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1322

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	75,455				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	195,108			8.00
9.00	00900	HOUSEKEEPING	3,205	0	71,677		9.00
10.00	01000	DIETARY	2,434	452	2,434	8,681	10.00
11.00	01100	CAFETERIA	2,454	984	2,454	0	11.00
13.00	01300	NURSING ADMINISTRATION	372	0	372	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	0	2,363	0	14.00
15.00	01500	PHARMACY	1,428	0	1,428	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,732	0	1,732	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,178	64,701	18,178	8,081	30.00
43.00	04300	NURSERY	372	1,007	372	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,477	20,929	10,477	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	767	1,475	767	0	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	27,671	7,506	0	54.00
60.00	06000	LABORATORY	4,509	7	4,509	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	65.00
66.00	06600	PHYSICAL THERAPY	5,072	16,721	5,072	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	68.00
69.00	06900	ELECTROCARDIOLOGY	179	5,828	179	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,681	0	1,681	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,997	50,206	5,997	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,530	189,981	70,752	8,081	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,127	0	600	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,252,626	361,872	1,019,835	706,741	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.106832	1.854727	14.228204	81.412395	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	879,046	21,571	108,104	90,371	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.649937	0.110559	1.508210	10.410206	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1322

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	138,072				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,500,055			14.00
15.00	01500	PHARMACY	0	13,608	1,788,392		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	210	0	4,290	16.00
17.00	01700	SOCIAL SERVICE	6,068	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,575	268,054	0	742	30.00
43.00	04300	NURSERY	5,854	5,855	0	93	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,735	713,278	0	491	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,570	2,382	0	42	52.00
53.00	05300	ANESTHESIOLOGY	7,513	25,975	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	126,777	0	365	54.00
60.00	06000	LABORATORY	0	728,704	0	381	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,508	0	77	65.00
66.00	06600	PHYSICAL THERAPY	0	25,142	0	29	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	339	0	4	67.00
68.00	06800	SPEECH PATHOLOGY	0	296	0	9	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,150	0	75	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	173,859	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	123,256	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,788,392	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	41	0	29	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	22	76.01
76.97	07697	CARDIAC REHABILITATION	0	4,724	0	7	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	37,757	264,897	0	1,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,072	2,500,055	1,788,392	4,229	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	61	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	574,983	531,330	1,018,792	1,254,078	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.164371	0.212527	0.569669	292.325874	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,997	79,467	71,039	76,933	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.152073	0.031786	0.039722	17.933100	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1322

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:07 am

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

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY & ER		1	30.00	-619,684
8.00		IV THERAPY		1	64.00	618,898
9.00		ER		1	91.00	786

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/22/2022 9:07 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	8,766,221		8,766,221	0	0	30.00	
43.00	04300	NURSERY	333,561		333,561	0	0	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,398,847		4,398,847	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	468,117		468,117	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	123,939		123,939	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,709,344		4,709,344	0	0	54.00	
60.00	06000	LABORATORY	4,354,207		4,354,207	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	618,898		618,898	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	947,099	0	947,099	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,859,651	0	2,859,651	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	331,257	0	331,257	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	130,343	0	130,343	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	580,172		580,172	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	262,494		262,494	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,092		186,092	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,338,835		3,338,835	0	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	590,142		590,142	0	0	76.00	
76.01	03950	DIABETIC EDUCATION	27,102		27,102	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	665,300		665,300	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	5,842,855		5,842,855	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	680,791		680,791	0	0	92.00	
200.00		Subtotal (see instructions)	40,215,267	0	40,215,267	0	0	200.00	
201.00		Less Observation Beds	680,791		680,791			201.00	
202.00		Total (see instructions)	39,534,476	0	39,534,476	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/22/2022 9:07 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,333,166		7,333,166		30.00
43.00	04300	NURSERY	314,290		314,290		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	728,154	8,578,694	9,306,848	0.472646	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,439,113	585,041	2,024,154	0.231266	52.00
53.00	05300	ANESTHESIOLOGY	243,594	1,171,498	1,415,092	0.087584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,921	44,886,227	45,996,148	0.102386	54.00
60.00	06000	LABORATORY	2,866,969	17,506,742	20,373,711	0.213717	60.00
64.00	06400	INTRAVENOUS THERAPY	3,704,648	381,883	4,086,531	0.151448	64.00
65.00	06500	RESPIRATORY THERAPY	774,470	1,826,767	2,601,237	0.364096	65.00
66.00	06600	PHYSICAL THERAPY	916,980	5,050,248	5,967,228	0.479226	66.00
67.00	06700	OCCUPATIONAL THERAPY	588,150	369,842	957,992	0.345783	67.00
68.00	06800	SPEECH PATHOLOGY	34,590	392,816	427,406	0.304963	68.00
69.00	06900	ELECTROCARDIOLOGY	261,898	4,853,442	5,115,340	0.113418	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,127,370	1,332,781	2,460,151	0.106698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,213	791,924	824,137	0.225802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,423,360	8,040,604	11,463,964	0.291246	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	487,445	487,445	1.210684	76.00
76.01	03950	DIABETIC EDUCATION	0	84,046	84,046	0.322466	76.01
76.97	07697	CARDIAC REHABILITATION	1,264	1,018,672	1,019,936	0.652296	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	793,871	21,129,395	21,923,266	0.266514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	134,514	1,557,488	1,692,002	0.402358	92.00
200.00		Subtotal (see instructions)	25,828,535	120,045,555	145,874,090		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,828,535	120,045,555	145,874,090		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03950	DIABETIC EDUCATION	0.000000			76.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	640,907	9,306,848	0.068864	21,185	1,459
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,915	2,024,154	0.023672	0	0
53.00	05300	ANESTHESIOLOGY	18,249	1,415,092	0.012896	23,151	299
54.00	05400	RADIOLOGY-DIAGNOSTIC	501,223	45,996,148	0.010897	339,506	3,700
60.00	06000	LABORATORY	290,715	20,373,711	0.014269	798,785	11,398
64.00	06400	INTRAVENOUS THERAPY	0	4,086,531	0.000000	1,257,898	0
65.00	06500	RESPIRATORY THERAPY	56,201	2,601,237	0.021605	312,202	6,745
66.00	06600	PHYSICAL THERAPY	222,178	5,967,228	0.037233	159,050	5,922
67.00	06700	OCCUPATIONAL THERAPY	6,303	957,992	0.006579	94,930	625
68.00	06800	SPEECH PATHOLOGY	5,625	427,406	0.013161	12,257	161
69.00	06900	ELECTROCARDIOLOGY	74,062	5,115,340	0.014478	109,947	1,592
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,845	2,460,151	0.003595	334,059	1,201
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,271	824,137	0.007609	5,423	41
73.00	07300	DRUGS CHARGED TO PATIENTS	105,185	11,463,964	0.009175	954,371	8,756
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,247	487,445	0.123598	0	0
76.01	03950	DIABETIC EDUCATION	701	84,046	0.008341	0	0
76.97	07697	CARDIAC REHABILITATION	143,566	1,019,936	0.140760	357	50
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	351,357	21,923,266	0.016027	1,746	28
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	72,795	1,692,002	0.043023	0	0
200.00		Total (lines 50 through 199)	2,612,345	138,226,634		4,424,867	41,977

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1322		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/22/2022 9:07 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1322		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/22/2022 9:07 am	
			Title XVIII		Hospital		Cost	
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								
50.00	05000	OPERATING ROOM	0	0	0	9,306,848	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,024,154	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,415,092	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,996,148	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,373,711	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	4,086,531	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,601,237	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,967,228	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	957,992	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	427,406	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,115,340	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,460,151	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	824,137	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,463,964	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	487,445	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	84,046	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,019,936	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	21,923,266	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,692,002	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	138,226,634		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	21,185	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,151	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	339,506	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	798,785	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,257,898	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	312,202	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	159,050	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	94,930	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	12,257	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	109,947	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	334,059	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,423	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	954,371	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	357	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	1,746	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,424,867	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/22/2022 9:07 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.472646	0	2,345,648	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.231266	0	3,831	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.087584	0	267,933	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102386	0	13,686,052	0	0	54.00
60.00	06000	LABORATORY	0.213717	0	4,894,425	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.151448	0	84,491	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.364096	0	496,910	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.479226	0	1,476,909	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345783	0	93,534	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304963	0	17,106	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113418	0	1,680,474	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106698	0	267,004	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225802	0	226,254	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.291246	0	3,544,674	1,324	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.210684	0	24,056	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.322466	0	8,396	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.652296	0	435,003	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.266514	0	5,516,275	11,767	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402358	0	399,072	0	0	92.00
200.00		Subtotal (see instructions)		0	35,468,047	13,091	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	35,468,047	13,091	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/22/2022 9:07 am

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,108,661	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	886	0		52.00
53.00	05300	ANESTHESIOLOGY	23,467	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,401,260	0		54.00
60.00	06000	LABORATORY	1,046,022	0		60.00
64.00	06400	INTRAVENOUS THERAPY	12,796	0		64.00
65.00	06500	RESPIRATORY THERAPY	180,923	0		65.00
66.00	06600	PHYSICAL THERAPY	707,773	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	32,342	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,217	0		68.00
69.00	06900	ELECTROCARDIOLOGY	190,596	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,489	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,089	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,032,372	386		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	29,124	0		76.00
76.01	03950	DIABETIC EDUCATION	2,707	0		76.01
76.97	07697	CARDIAC REHABILITATION	283,751	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,470,165	3,136		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	160,570	0		92.00
200.00		Subtotal (see instructions)	7,768,210	3,522		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,768,210	3,522		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/22/2022 9:07 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,645	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,007	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,592	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		684	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1,618	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		113	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)		223	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,263	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)		572	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1,050	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,766,221	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)		19,177	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)		37,845	25.00
26.00	Total swing-bed cost (see instructions)		3,833,361	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,932,860	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)		4,932,860	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,640.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,071,901	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,071,901	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1322

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

Worksheet D-1

Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		Title XVIII		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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					962,470	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,034,371	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)					938,343	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,722,483	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,660,826	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)					415	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,640.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					680,791	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1322

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

Worksheet D-1

Date/Time Prepared:
2/22/2022 9:07 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	937,346	8,766,221	0.106927	680,791	72,795	90.00
91.00	Nursing Program cost	0	8,766,221	0.000000	680,791	0	91.00
92.00	Allied health cost	0	8,766,221	0.000000	680,791	0	92.00
93.00	All other Medical Education	0	8,766,221	0.000000	680,791	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/22/2022 9:07 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		2,378,485		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.472646	21,185	10,013	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.231266	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.087584	23,151	2,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102386	339,506	34,761	54.00
60.00	06000	LABORATORY	0.213717	798,785	170,714	60.00
64.00	06400	INTRAVENOUS THERAPY	0.151448	1,257,898	190,506	64.00
65.00	06500	RESPIRATORY THERAPY	0.364096	312,202	113,671	65.00
66.00	06600	PHYSICAL THERAPY	0.479226	159,050	76,221	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.345783	94,930	32,825	67.00
68.00	06800	SPEECH PATHOLOGY	0.304963	12,257	3,738	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113418	109,947	12,470	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106698	334,059	35,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225802	5,423	1,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.291246	954,371	277,957	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.210684	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.322466	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.652296	357	233	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.266514	1,746	465	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402358	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,424,867	962,470	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,424,867		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3
			Component CCN: 14-Z322		Date/Time Prepared: 2/22/2022 9:07 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.472646	8,216	3,883
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.231266	0	0
53.00	05300	ANESTHESIOLOGY	0.087584	7,142	626
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102386	204,472	20,935
60.00	06000	LABORATORY	0.213717	454,816	97,202
64.00	06400	INTRAVENOUS THERAPY	0.151448	684,050	103,598
65.00	06500	RESPIRATORY THERAPY	0.364096	156,422	56,953
66.00	06600	PHYSICAL THERAPY	0.479226	349,313	167,400
67.00	06700	OCCUPATIONAL THERAPY	0.345783	217,645	75,258
68.00	06800	SPEECH PATHOLOGY	0.304963	10,120	3,086
69.00	06900	ELECTROCARDIOLOGY	0.113418	13,883	1,575
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106698	250,033	26,678
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225802	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.291246	598,306	174,254
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.210684	0	0
76.01	03950	DIABETIC EDUCATION	0.322466	0	0
76.97	07697	CARDIAC REHABILITATION	0.652296	316	206
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.266514	95	25
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.402358	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,954,829	731,679
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		2,954,829	731,679

Health Financial Systems		ABRAHAM LINCOLN MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/22/2022 9:07 am	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			7,771,732	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	OPPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,771,732	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			7,849,449	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			52,709	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,930,620	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,866,120	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			1,866,120	30.00
31.00	Primary payer payments			283	31.00
32.00	Subtotal (line 30 minus line 31)			1,865,837	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			1,080,256	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			702,166	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			756,217	36.00
37.00	Subtotal (see instructions)			2,568,003	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2,568,003	40.00
40.01	Sequestration adjustment (see instructions)			0	40.01
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0	40.03
41.00	Interim payments			2,423,504	41.00
41.01	Interim payments-PARHM			0	41.01
42.00	Tentative settlement (for contractors use only)			0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0	42.01
43.00	Balance due provider/program (see instructions)			144,499	43.00
43.01	Balance due provider/program-PARHM (see instructions)			0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/22/2022 9:07 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,039,958		2,565,973	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	05/12/2021	262,498	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	05/12/2021	153,999	08/25/2021	404,967	3.50
3.51		08/25/2021	35,800		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-189,799		-142,469	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,850,159		2,423,504	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		144,499	6.01
6.02	SETTLEMENT TO PROGRAM		42,456		0	6.02
7.00	Total Medicare program liability (see instructions)		2,807,703		2,568,003	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1322

Period:

Worksheet E-1

Component CCN: 14-Z322

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/22/2022 9:07 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,817,006		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	05/12/2021	180,661		0	3.50
3.51		08/25/2021	441,681		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-622,342		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,194,664		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		178,899		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,373,563		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/22/2022 9:07 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1322

Period:

From 10/01/2020

To 09/30/2021

Worksheet E-2

Component CCN: 14-Z322

Date/Time Prepared:

2/22/2022 9:07 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,687,434	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		738,996	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,622	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3,426,430	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,426,430	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		3,426,430	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		63,163	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		3,363,267	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		15,840	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		10,296	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		15,488	0	18.00
19.00	Total (see instructions)		3,373,563	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		3,194,664	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		178,899	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1322	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/22/2022 9:07 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,034,371	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,034,371	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,064,715	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,064,715	19.00
20.00	Deductibles (exclude professional component)		301,068	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,763,647	22.00
23.00	Coinsurance		3,710	23.00
24.00	Subtotal (line 22 minus line 23)		2,759,937	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		73,486	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		47,766	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		60,790	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,807,703	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,807,703	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		2,850,159	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-42,456	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1322

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

Worksheet G

Date/Time Prepared:
2/22/2022 9:07 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	3,279,322	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	12,359,347	0	0	0	4.00
5.00 Other receivable	442,162	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-3,823,847	0	0	0	6.00
7.00 Inventory	570,045	0	0	0	7.00
8.00 Prepaid expenses	387,995	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	31,214	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	13,246,238	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,421,216	0	0	0	12.00
13.00 Land improvements	6,333,183	0	0	0	13.00
14.00 Accumulated depreciation	-4,440,128	0	0	0	14.00
15.00 Buildings	44,650,230	0	0	0	15.00
16.00 Accumulated depreciation	-26,568,488	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	18,575,971	0	0	0	23.00
24.00 Accumulated depreciation	-14,912,051	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	1,313,058	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	26,372,991	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	105,288,776	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	38,644,851	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	143,933,627	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	183,552,856	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	3,375,771	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,381,886	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	-17,490,308	0	0	0	40.00
41.00 Deferred income	5,818,673	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	400,560	0	0	0	43.00
44.00 Other current liabilities	51,513	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	-5,461,905	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	-5,461,905	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	189,014,761	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	189,014,761	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	183,552,856	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1322

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

Worksheet G-1

Date/Time Prepared:
2/22/2022 9:07 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		153,955,163		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		36,994,600				2.00
3.00	Total (sum of line 1 and line 2)		190,949,763		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		190,949,763		0		11.00
12.00	CHANGE IN RESTRICTED ASSETS	1,935,002		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,935,002		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		189,014,761		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN RESTRICTED ASSETS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/22/2022 9:07 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,975,990		3,975,990	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,978,755		2,978,755	5.00
6.00	Swing bed - NF	434,780		434,780	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)	7,389,525		7,389,525	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)	7,389,525		7,389,525	17.00
18.00	Ancillary services	17,403,013	99,031,660	116,434,673	18.00
19.00	Outpatient services	942,263	22,938,424	23,880,687	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	316,662	0	316,662	27.00
27.01	PROFESSIONAL FEES	774,355	12,152,089	12,926,444	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,825,818	134,122,173	160,947,991	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46,348,444		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		46,348,444		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1322

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

Worksheet G-3

Date/Time Prepared:
2/22/2022 9:07 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	160,947,991	1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,829,135	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,118,856	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	46,348,444	4.00
5.00	Net income from service to patients (line 3 minus line 4)	14,770,412	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	52,152	6.00
7.00	Income from investments	725,603	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	44	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	122,162	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	3,610	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	8,942	22.00
23.00	Governmental appropriations	0	23.00
24.00	REALIZED GAIN/LOSS ON INVESTMENTS	3,974,092	24.00
24.01	UNREALIZED GAIN/LOSS ON INVESTMENTS	10,828,977	24.01
24.02	CHANGE IN INTEREST IN FOUNDATION	5,458,122	24.02
24.03	MISCELLANEOUS INCOME	53,199	24.03
24.50	COVID-19 PHE Funding	1,054,972	24.50
25.00	Total other income (sum of lines 6-24)	22,281,875	25.00
26.00	Total (line 5 plus line 25)	37,052,287	26.00
27.00	PROVISION FOR INCOME TAXES	14,866	27.00
27.01	INVESTMENT FEES	22,516	27.01
27.02	SALE OF AR TRUST FEES	5,378	27.02
27.03	LOSS ON DISPOSAL OF FIXED ASSETS	14,927	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	57,687	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	36,994,600	29.00