

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: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/22/2022 9:17 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 TAYLORVILLE MEMORIAL HOSPITAL (14-1339) 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	-114,470	948,308	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	-329,550	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	-444,020	948,308	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: 14-1339		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:17 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 201 EAST PLEASANT STREET			PO Box:				1.00	
2.00	City: TAYLORVILLE			State: IL		Zip Code: 62568		County: CHRISTIAN 2.00	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	N	O
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.					1	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/22/2022 9:17 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.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1339		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:17 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)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				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)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:17 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	30,306	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1339		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/22/2022 9:17 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 HEALTH SYSTEMS		Contractor's Name: MEMORIAL HEALTH SYSTEMS		Contractor's Number: 00131		141.00			
142.00	Street: 701 NORTH FIRST STREET		PO Box:				142.00			
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62781		143.00			
								1.00		
144.00 Are provider based physicians' costs included in Worksheet A?								Y		144.00
								1.00		
								2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00	
								1.00		
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N		147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N		148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N		149.00
				Part A		Part B		Title V		
				1.00		2.00		3.00		
								Title XIX		
				1.00		2.00		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		155.00
156.00	Subprovider - IPF			N		N		N		156.00
157.00	Subprovider - IRF			N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N		N		N		159.00
160.00	HOME HEALTH AGENCY			N		N		N		160.00
161.00	CMHC			N		N		N		161.00
								1.00		
Multicampus										
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N		165.00
				Name		County		State		
				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: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/22/2022 9:17 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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/22/2022 9:17 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
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		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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/22/2022 9:17 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	50,139.00	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	50,139.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	50,139.00	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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/22/2022 9:17 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)	1,218	64	2,123			1.00
2.00	HMO and other (see instructions)	234	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	2,533	0	3,486			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	228			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,751	64	5,837			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)	3,751	64	5,837	0.00	252.49	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	252.49	27.00
28.00	Observation Bed Days		0	375			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			14			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/22/2022 9:17 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	287	17	493	1.00
2.00 HMO and other (see instructions)			31	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	287	17	493	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: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/22/2022 9:17 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)			0.317026 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	3,669,492		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	23,111,444		6.00
7.00	Medicaid cost (line 1 times line 6)	7,326,929		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)	3,657,437		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	74,488		9.00
10.00	Stand-alone CHIP charges	175,204		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	55,544		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)	3,657,437		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)	258,077	182,255	440,332 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	81,817	182,255	264,072 21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,372	0	1,372 22.00
23.00	Cost of charity care (line 21 minus line 22)	80,445	182,255	262,700 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)	1,115,660		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	612,840		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	942,830		27.01
28.00	Non-Medicare bad debt expense (see instructions)	172,830		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	384,782		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	647,482		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,304,919		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1339

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

Worksheet A

Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,590,017	3,590,017	439,466	4,029,483	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,895,458	1,895,458	74,853	1,970,311	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	801,108	4,239,898	5,041,006	-83,189	4,957,817	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,438,693	6,091,991	8,530,684	-30,889	8,499,795	5.00
7.00	00700	OPERATION OF PLANT	794,705	737,248	1,531,953	0	1,531,953	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,036	171,870	186,906	0	186,906	8.00
9.00	00900	HOUSEKEEPING	401,902	184,522	586,424	0	586,424	9.00
10.00	01000	DIETARY	421,683	314,086	735,769	-416,544	319,225	10.00
11.00	01100	CAFETERIA	0	0	0	409,859	409,859	11.00
13.00	01300	NURSING ADMINISTRATION	507,620	29,648	537,268	0	537,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,071	62,009	174,080	-166	173,914	14.00
15.00	01500	PHARMACY	567,524	1,972,613	2,540,137	-1,927,104	613,033	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	464,145	1,067	465,212	0	465,212	16.00
17.00	01700	SOCIAL SERVICE	65,299	104	65,403	0	65,403	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	729,552	0	729,552	83,189	812,741	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,240,856	943,242	3,184,098	-952	3,183,146	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	606,218	690,666	1,296,884	-288,802	1,008,082	50.00
53.00	05300	ANESTHESIOLOGY	35,670	108,395	144,065	-25,866	118,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,329,246	724,469	2,053,715	-5,088	2,048,627	54.00
60.00	06000	LABORATORY	986,385	1,347,211	2,333,596	-38	2,333,558	60.00
64.00	06400	INTRAVENOUS THERAPY	211,095	58,681	269,776	-246	269,530	64.00
65.00	06500	RESPIRATORY THERAPY	535,091	114,983	650,074	-56,137	593,937	65.00
66.00	06600	PHYSICAL THERAPY	1,084,589	22,213	1,106,802	0	1,106,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	331,825	4,592	336,417	0	336,417	67.00
68.00	06800	SPEECH PATHOLOGY	163,749	805	164,554	0	164,554	68.00
69.00	06900	ELECTROCARDIOLOGY	122,629	14,216	136,845	-6	136,839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	143,332	143,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	236,896	236,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,936,376	1,936,376	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	174,622	168,943	343,565	0	343,565	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	6,685	6,685	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,873,525	3,032,046	4,905,571	-12,199	4,893,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		483,430	483,430	-483,430	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,014,838	27,004,423	44,019,261	0	44,019,261	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	928	928	0	928	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	17,014,838	27,005,351	44,020,189	0	44,020,189	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1339

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

Worksheet A

Date/Time Prepared:
2/22/2022 9:17 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	-536,289	3,493,194	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	176,188	2,146,499	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-45,228	4,912,589	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,139,819	7,359,976	5.00
7.00	00700	OPERATION OF PLANT	-14,852	1,517,101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	186,906	8.00
9.00	00900	HOUSEKEEPING	0	586,424	9.00
10.00	01000	DIETARY	0	319,225	10.00
11.00	01100	CAFETERIA	-97,135	312,724	11.00
13.00	01300	NURSING ADMINISTRATION	0	537,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	173,914	14.00
15.00	01500	PHARMACY	0	613,033	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,666	455,546	16.00
17.00	01700	SOCIAL SERVICE	0	65,403	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-812,741	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-273,750	2,909,396	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,848	1,015,930	50.00
53.00	05300	ANESTHESIOLOGY	-54,046	64,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,048,627	54.00
60.00	06000	LABORATORY	0	2,333,558	60.00
64.00	06400	INTRAVENOUS THERAPY	0	269,530	64.00
65.00	06500	RESPIRATORY THERAPY	0	593,937	65.00
66.00	06600	PHYSICAL THERAPY	0	1,106,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	336,417	67.00
68.00	06800	SPEECH PATHOLOGY	0	164,554	68.00
69.00	06900	ELECTROCARDIOLOGY	0	136,839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	143,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	236,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,936,376	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	343,565	76.00
76.01	03950	DIABETIC EDUCATION	0	6,685	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-1,808,640	3,084,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,608,130	39,411,131	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	928	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,608,130	39,412,059	200.00

RECLASSIFICATIONS

Provider CCN: 14-1339

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

Worksheet A-6

Date/Time Prepared:
2/22/2022 9:17 am

Increases					
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	233,294	176,565	1.00
2.00	DIABETIC EDUCATION	76.01	6,685	0	2.00
0			239,979	176,565	
B - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,936,376	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
0			0	1,936,376	
C - IMPLANTS & MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	143,332	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	236,896	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
0			0	380,228	
D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	30,889	1.00
0			0	30,889	
E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	577,517	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	58,109	2.00
0			0	635,626	
F - BOND AMORTIZATION EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	152,196	1.00
0			0	152,196	
G - CRNA BENEFITS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	83,189	1.00
0			0	83,189	
500.00	Grand Total: Increases		239,979	3,395,069	500.00

RECLASSIFICATIONS

Provider CCN: 14-1339

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

Worksheet A-6

Date/Time Prepared:
2/22/2022 9:17 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	239,979	176,565	0	1.00
2.00		0.00	0	0	0	2.00
	0		239,979	176,565		
B - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	1,927,104	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	952	0	2.00
3.00	OPERATING ROOM	50.00	0	1,035	0	3.00
4.00	ANESTHESIOLOGY	53.00	0	1,268	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,088	0	5.00
6.00	LABORATORY	60.00	0	38	0	6.00
7.00	INTRAVENOUS THERAPY	64.00	0	246	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	560	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	6	0	9.00
10.00	EMERGENCY	91.00	0	79	0	10.00
	0		0	1,936,376		
C - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	166	0	1.00
2.00	OPERATING ROOM	50.00	0	287,767	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	24,598	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	55,577	0	4.00
5.00	EMERGENCY	91.00	0	12,120	0	5.00
	0		0	380,228		
D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,889	0	1.00
	0		0	30,889		
E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	635,626	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	635,626		
F - BOND AMORTIZATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	152,196	14	1.00
	0		0	152,196		
G - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	83,189	0	1.00
	0		0	83,189		
500.00	Grand Total: Decreases		239,979	3,395,069		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/22/2022 9:17 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	1,058,695	0	0	0	110,625	1.00	
2.00	Land Improvements	4,148,030	0	0	0	0	2.00	
3.00	Buildings and Fixtures	16,767,579	165,772	0	165,772	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	24,510,710	1,901,427	0	1,901,427	336,243	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	46,485,014	2,067,199	0	2,067,199	446,868	8.00	
9.00	Reconciling Items	-46,433,314	-21,920,399	0	-21,920,399	-14,766,048	9.00	
10.00	Total (line 8 minus line 9)	92,918,328	23,987,598	0	23,987,598	15,212,916	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	948,070	0					1.00
2.00	Land Improvements	4,148,030	0					2.00
3.00	Buildings and Fixtures	16,933,351	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	26,075,894	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	48,105,345	0					8.00
9.00	Reconciling Items	-53,587,665	0					9.00
10.00	Total (line 8 minus line 9)	101,693,010	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,590,017	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,895,458	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,485,475	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	3,590,017				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,895,458				2.00
3.00	Total (sum of lines 1-2)	0	5,485,475				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/22/2022 9:17 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	22,029,451	0	22,029,451	0.457942	14,145	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,075,894	0	26,075,894	0.542058	16,744	2.00
3.00	Total (sum of lines 1-2)	48,105,345	0	48,105,345	1.000000	30,889	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	14,145	3,631,245	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	16,744	2,129,755	0	2.00
3.00	Total (sum of lines 1-2)	0	0	30,889	5,761,000	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	14,145	0	-152,196	3,493,194	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,744	0	0	2,146,499	2.00
3.00	Total (sum of lines 1-2)	0	30,889	0	-152,196	5,639,693	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1339

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

Worksheet A-8

Date/Time Prepared:
2/22/2022 9:17 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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-577,517	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-58,109	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-10,069	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,347	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-14,852	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,300,046			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	796,323			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-97,135	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	-9,666	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	-812,741	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		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-70,634	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1339

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

Worksheet A-8

Date/Time Prepared:
2/22/2022 9:17 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	MISC INCOME - OR	B	-248	OPERATING ROOM	50.00	0	33.01
34.00	PROVIDER TAX	A	-1,454,374	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MUTUAL FUND FEES	A	41,933	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADVERTISING EXPENSE	A	-16,049	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSE	A	-19,099	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DONATION EXPENSE	A	-500	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,608,130				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: 14-1339

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

Worksheet A-8-1

Date/Time Prepared:
2/22/2022 9:17 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	37,068	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	60,637	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	4,160	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	173,660	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	10,069	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,299,597	1,743,640	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2,526,585	2,571,813	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	377,254	377,254	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,489,030	4,692,707	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 HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	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: 14-1339

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

Worksheet A-8-1

Date/Time Prepared:
2/22/2022 9:17 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	37,068	9		1.00
2.00	60,637	9		2.00
3.00	4,160	9		3.00
4.00	173,660	9		4.00
4.01	10,069	0		4.01
4.02	555,957	0		4.02
4.03	-45,228	0		4.03
4.04	0	0		4.04
5.00	796,323			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	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		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: 14-1339

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

Worksheet A-8-2

Date/Time Prepared:
2/22/2022 9:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	171,706	171,706	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	273,750	273,750	0	0	0	2.00
3.00	50.00	OPERATING ROOM	-8,096	-8,096	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	54,046	54,046	0	0	0	4.00
5.00	91.00	EMERGENCY	2,713,308	1,808,640	904,668	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			3,204,714	2,300,046	904,668		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	171,706		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	273,750		2.00
3.00	50.00	OPERATING ROOM	0	0	0	-8,096		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	54,046		4.00
5.00	91.00	EMERGENCY	0	0	0	1,808,640		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	2,300,046		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,493,194	3,493,194			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,146,499		2,146,499		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,912,589	0	0	4,912,589	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,359,976	222,951	1,132,977	773,714	9,489,618
7.00	00700	OPERATION OF PLANT	1,517,101	983,983	33,824	252,132	2,787,040
8.00	00800	LAUNDRY & LINEN SERVICE	186,906	0	0	4,770	191,676
9.00	00900	HOUSEKEEPING	586,424	65,909	4,609	127,509	784,451
10.00	01000	DIETARY	319,225	13,946	3,779	57,649	394,599
11.00	01100	CAFETERIA	312,724	171,649	4,853	74,016	563,242
13.00	01300	NURSING ADMINISTRATION	537,268	4,539	1,943	161,050	704,800
14.00	01400	CENTRAL SERVICES & SUPPLY	173,914	91,821	0	35,556	301,291
15.00	01500	PHARMACY	613,033	68,440	163,101	180,056	1,024,630
16.00	01600	MEDICAL RECORDS & LIBRARY	455,546	11,636	1,251	147,257	615,690
17.00	01700	SOCIAL SERVICE	65,403	3,383	0	20,717	89,503
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,909,396	533,212	61,559	710,945	4,215,112
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,015,930	351,385	282,788	192,332	1,842,435
53.00	05300	ANESTHESIOLOGY	64,153	4,044	38,335	11,317	117,849
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,048,627	206,144	288,402	421,723	2,964,896
60.00	06000	LABORATORY	2,333,558	127,141	57,058	312,945	2,830,702
64.00	06400	INTRAVENOUS THERAPY	269,530	78,452	0	66,973	414,955
65.00	06500	RESPIRATORY THERAPY	593,937	29,021	9,594	169,766	802,318
66.00	06600	PHYSICAL THERAPY	1,106,802	136,109	8,056	344,102	1,595,069
67.00	06700	OCCUPATIONAL THERAPY	336,417	63,213	0	105,276	504,906
68.00	06800	SPEECH PATHOLOGY	164,554	3,026	0	51,952	219,532
69.00	06900	ELECTROCARDIOLOGY	136,839	44,260	5,171	38,906	225,176
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	143,332	0	0	0	143,332
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	236,896	0	0	0	236,896
73.00	07300	DRUGS CHARGED TO PATIENTS	1,936,376	0	0	0	1,936,376
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	343,565	62,250	0	55,401	461,216
76.01	03950	DIABETIC EDUCATION	6,685	0	0	2,121	8,806
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,084,732	199,047	49,199	594,404	3,927,382
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,411,131	3,475,561	2,146,499	4,912,589	39,393,498
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,633	0	0	17,633
192.00	19200	PHYSICIANS' PRIVATE OFFICES	928	0	0	0	928
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	39,412,059	3,493,194	2,146,499	4,912,589	39,412,059

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,489,618					5.00
7.00	00700	OPERATION OF PLANT	883,885	3,670,925				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,788	0	252,464			8.00
9.00	00900	HOUSEKEEPING	248,782	105,826	4,983	1,144,042		9.00
10.00	01000	DIETARY	125,144	22,393	3,340	5,138	550,614	10.00
11.00	01100	CAFETERIA	178,627	275,608	0	2,398	0	11.00
13.00	01300	NURSING ADMINISTRATION	223,521	7,288	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,552	147,432	796	0	0	14.00
15.00	01500	PHARMACY	324,952	109,890	0	7,536	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,261	18,683	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	28,385	5,433	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	1,336,768	856,149	124,561	396,304	550,614	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	584,312	564,200	19,930	128,790	0	50.00
53.00	05300	ANESTHESIOLOGY	37,375	6,493	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	940,290	330,994	19,131	56,860	0	54.00
60.00	06000	LABORATORY	897,732	204,144	399	41,446	0	60.00
64.00	06400	INTRAVENOUS THERAPY	131,599	125,967	0	44,529	0	64.00
65.00	06500	RESPIRATORY THERAPY	254,448	46,597	0	20,894	0	65.00
66.00	06600	PHYSICAL THERAPY	505,862	218,543	17,041	52,407	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,126	101,498	0	24,319	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,623	4,858	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	71,413	71,066	0	3,768	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,456	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,129	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	614,104	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	146,271	99,952	0	10,276	0	76.00
76.01	03950	DIABETIC EDUCATION	2,793	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,245,534	319,599	62,283	272,994	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,483,732	3,642,613	252,464	1,067,659	550,614	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,592	28,312	0	2,740	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	294	0	0	73,643	0	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)	9,489,618	3,670,925	252,464	1,144,042	550,614	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1339

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	1,019,875				11.00
13.00	01300	NURSING ADMINISTRATION	44,335	979,944			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,069	0	548,140		14.00
15.00	01500	PHARMACY	29,210	0	1,370	1,497,588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,353	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	20,770	37,811	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	270,013	505,224	61,039	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,567	71,832	83,893	0	50.00
53.00	05300	ANESTHESIOLOGY	17,756	32,280	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,167	0	24,349	0	54.00
60.00	06000	LABORATORY	122,319	0	200,582	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	10,036	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,280	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	64,064	0	2,313	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,762	0	412	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	28	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,289	0	1,062	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	40,288	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	66,587	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,497,588	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,771	0	124	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	183,150	332,797	56,039	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,019,875	979,944	548,123	1,497,588	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	17	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,019,875	979,944	548,140	1,497,588	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1339

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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	181,902					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	181,902	0	8,699,977	-67,884	8,632,093	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	3,404,874	778	3,405,652	50.00
53.00	05300	ANESTHESIOLOGY	0	0	211,753	0	211,753	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,447,445	0	4,447,445	54.00
60.00	06000	LABORATORY	0	0	4,383,564	0	4,383,564	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	751,574	67,106	818,680	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,181,572	0	1,181,572	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,458,138	0	2,458,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	850,088	0	850,088	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	294,041	0	294,041	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	394,421	0	394,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	229,076	0	229,076	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	378,612	0	378,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,048,068	0	4,048,068	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	751,128	0	751,128	76.00
76.01	03950	DIABETIC EDUCATION	0	0	11,599	0	11,599	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	6,786,970	0	6,786,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,902	0	39,282,900	0	39,282,900	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	54,277	0	54,277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	74,882	0	74,882	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	181,902	0	39,412,059	0	39,412,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	286	222,951	1,132,977	1,356,214	5.00
7.00	00700	OPERATION OF PLANT	0	983,983	33,824	1,017,807	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	65,909	4,609	70,518	9.00
10.00	01000	DIETARY	71,589	13,946	3,779	89,314	10.00
11.00	01100	CAFETERIA	0	171,649	4,853	176,502	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,539	1,943	6,482	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,218	91,821	0	94,039	14.00
15.00	01500	PHARMACY	0	68,440	163,101	231,541	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,636	1,251	12,887	16.00
17.00	01700	SOCIAL SERVICE	0	3,383	0	3,383	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,178	533,212	61,559	622,949	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	350	351,385	282,788	634,523	50.00
53.00	05300	ANESTHESIOLOGY	0	4,044	38,335	42,379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	206,144	288,402	494,546	54.00
60.00	06000	LABORATORY	0	127,141	57,058	184,199	60.00
64.00	06400	INTRAVENOUS THERAPY	0	78,452	0	78,452	64.00
65.00	06500	RESPIRATORY THERAPY	2,003	29,021	9,594	40,618	65.00
66.00	06600	PHYSICAL THERAPY	0	136,109	8,056	144,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	63,213	0	63,213	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,026	0	3,026	68.00
69.00	06900	ELECTROCARDIOLOGY	0	44,260	5,171	49,431	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	62,250	0	62,250	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	199,047	49,199	248,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,624	3,475,561	2,146,499	5,726,684	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,633	0	17,633	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)	104,624	3,493,194	2,146,499	5,744,317	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,356,214					5.00
7.00	00700	OPERATION OF PLANT	126,320	1,144,127				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,688	0	8,688			8.00
9.00	00900	HOUSEKEEPING	35,554	32,983	171	139,226		9.00
10.00	01000	DIETARY	17,885	6,979	115	625	114,918	10.00
11.00	01100	CAFETERIA	25,528	85,899	0	292	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,944	2,271	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,656	45,951	27	0	0	14.00
15.00	01500	PHARMACY	46,440	34,250	0	917	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,906	5,823	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,057	1,693	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	191,056	266,840	4,288	48,228	114,918	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	83,507	175,846	686	15,673	0	50.00
53.00	05300	ANESTHESIOLOGY	5,341	2,024	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,381	103,162	658	6,920	0	54.00
60.00	06000	LABORATORY	128,299	63,626	14	5,044	0	60.00
64.00	06400	INTRAVENOUS THERAPY	18,807	39,260	0	5,419	0	64.00
65.00	06500	RESPIRATORY THERAPY	36,364	14,523	0	2,543	0	65.00
66.00	06600	PHYSICAL THERAPY	72,295	68,114	586	6,378	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,884	31,634	0	2,960	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,950	1,514	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,206	22,149	0	459	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,496	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,737	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,764	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,904	31,152	0	1,251	0	76.00
76.01	03950	DIABETIC EDUCATION	399	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	178,005	99,610	2,143	33,222	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,355,373	1,135,303	8,688	129,931	114,918	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	799	8,824	0	333	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42	0	0	8,962	0	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)	1,356,214	1,144,127	8,688	139,226	114,918	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1339

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	288,221					11.00
13.00	01300	NURSING ADMINISTRATION	12,529	53,226				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	867	0	154,540			14.00
15.00	01500	PHARMACY	8,255	0	386	321,789		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,295	0	0	0	67,911	16.00
17.00	01700	SOCIAL SERVICE	5,870	2,054	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	76,307	27,441	17,209	0	15,180	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,182	3,902	23,652	0	5,246	50.00
53.00	05300	ANESTHESIOLOGY	5,018	1,753	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	0	6,865	0	7,111	54.00
60.00	06000	LABORATORY	34,568	0	56,551	0	6,472	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	2,830	0	1,838	64.00
65.00	06500	RESPIRATORY THERAPY	11,383	0	0	0	1,278	65.00
66.00	06600	PHYSICAL THERAPY	18,105	0	652	0	213	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,324	0	116	0	80	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	8	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,190	0	299	0	799	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,359	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,773	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	321,789	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,000	0	35	0	639	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	51,759	18,076	15,800	0	29,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	288,221	53,226	154,535	321,789	67,911	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	5	0	0	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)	288,221	53,226	154,540	321,789	67,911	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	17,057					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,057		1,401,473	0	1,401,473	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		954,217	0	954,217	50.00
53.00	05300	ANESTHESIOLOGY	0		56,515	0	56,515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		758,212	0	758,212	54.00
60.00	06000	LABORATORY	0		478,773	0	478,773	60.00
64.00	06400	INTRAVENOUS THERAPY	0		146,606	0	146,606	64.00
65.00	06500	RESPIRATORY THERAPY	0		106,709	0	106,709	65.00
66.00	06600	PHYSICAL THERAPY	0		310,508	0	310,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		137,211	0	137,211	67.00
68.00	06800	SPEECH PATHOLOGY	0		14,498	0	14,498	68.00
69.00	06900	ELECTROCARDIOLOGY	0		86,533	0	86,533	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		17,855	0	17,855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		29,510	0	29,510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		409,553	0	409,553	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		123,231	0	123,231	76.00
76.01	03950	DIABETIC EDUCATION	0		399	0	399	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0		675,916	0	675,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,057	0	5,707,719	0	5,707,719	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		27,589	0	27,589	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		9,009	0	9,009	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)	17,057	0	5,744,317	0	5,744,317	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1339

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:17 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	126,989					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,129,755				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,484,179			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,105	1,124,139	2,438,693	-9,489,618	29,922,441	5.00
7.00	00700	OPERATION OF PLANT	35,771	33,560	794,705	0	2,787,040	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	15,036	0	191,676	8.00
9.00	00900	HOUSEKEEPING	2,396	4,573	401,902	0	784,451	9.00
10.00	01000	DIETARY	507	3,750	181,705	0	394,599	10.00
11.00	01100	CAFETERIA	6,240	4,815	233,294	0	563,242	11.00
13.00	01300	NURSING ADMINISTRATION	165	1,928	507,620	0	704,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	0	112,071	0	301,291	14.00
15.00	01500	PHARMACY	2,488	161,829	567,524	0	1,024,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	423	1,241	464,145	0	615,690	16.00
17.00	01700	SOCIAL SERVICE	123	0	65,299	0	89,503	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,384	61,079	2,240,856	0	4,215,112	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,774	280,582	606,218	0	1,842,435	50.00
53.00	05300	ANESTHESIOLOGY	147	38,036	35,670	0	117,849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,494	286,152	1,329,246	0	2,964,896	54.00
60.00	06000	LABORATORY	4,622	56,613	986,385	0	2,830,702	60.00
64.00	06400	INTRAVENOUS THERAPY	2,852	0	211,095	0	414,955	64.00
65.00	06500	RESPIRATORY THERAPY	1,055	9,519	535,091	0	802,318	65.00
66.00	06600	PHYSICAL THERAPY	4,948	7,993	1,084,589	0	1,595,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,298	0	331,825	0	504,906	67.00
68.00	06800	SPEECH PATHOLOGY	110	0	163,749	0	219,532	68.00
69.00	06900	ELECTROCARDIOLOGY	1,609	5,131	122,629	0	225,176	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	143,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	236,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,936,376	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,263	0	174,622	0	461,216	76.00
76.01	03950	DIABETIC EDUCATION	0	0	6,685	0	8,806	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	7,236	48,815	1,873,525	0	3,927,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,348	2,129,755	15,484,179	-9,489,618	29,903,880	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	641	0	0	0	17,633	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	928	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)	3,493,194	2,146,499	4,912,589		9,489,618	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.507847	1.007862	0.317265		0.317141	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		1,356,214	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.045324	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: 14-1339

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	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	83,113				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	219,190			8.00
9.00	00900	HOUSEKEEPING	2,396	4,326	3,340		9.00
10.00	01000	DIETARY	507	2,900	15	25,201	10.00
11.00	01100	CAFETERIA	6,240	0	7	0	11.00
13.00	01300	NURSING ADMINISTRATION	165	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	691	0	0	14.00
15.00	01500	PHARMACY	2,488	0	22	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	423	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	123	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	19,384	108,145	1,157	25,201	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,774	17,303	376	0	50.00
53.00	05300	ANESTHESIOLOGY	147	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,494	16,610	166	0	54.00
60.00	06000	LABORATORY	4,622	346	121	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,852	0	130	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,055	0	61	0	65.00
66.00	06600	PHYSICAL THERAPY	4,948	14,795	153	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,298	0	71	0	67.00
68.00	06800	SPEECH PATHOLOGY	110	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,609	0	11	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	2,263	0	30	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	7,236	54,074	797	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,472	219,190	3,117	25,201	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	641	0	8	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	215	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)	3,670,925	252,464	1,144,042	550,614	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.167880	1.151804	342.527545	21.848895	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,144,127	8,688	139,226	114,918	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.765921	0.039637	41.684431	4.560057	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: 14-1339

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

Worksheet B-1

Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING 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	154,852					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,950,112				14.00
15.00	01500	PHARMACY	0	4,875	1,936,376			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3	0	2,550		16.00
17.00	01700	SOCIAL SERVICE	5,975	0	0	0	5,975	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,836	217,157	0	570	5,975	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,351	298,464	0	197	0	50.00
53.00	05300	ANESTHESIOLOGY	5,101	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,626	0	267	0	54.00
60.00	06000	LABORATORY	0	713,610	0	243	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	35,706	0	69	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	48	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,229	0	8	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,465	0	3	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	99	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,777	0	30	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	143,332	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	236,896	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,936,376	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	442	0	24	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	52,589	199,371	0	1,091	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	154,852	1,950,052	1,936,376	2,550	5,975	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	60	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)	979,944	548,140	1,497,588	904,988	181,902	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.328262	0.281081	0.773397	354.897255	30.443849	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,226	154,540	321,789	67,911	17,057	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.343722	0.079247	0.166181	26.631765	2.854728	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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet B-1
Date/Time Prepared:
2/22/2022 9:17 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	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.01	03950	DIABETIC EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

Provider CCN: 14-1339
Period: From 10/01/2020 To 09/30/2021
Worksheet B-2
Date/Time Prepared: 2/22/2022 9:17 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
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 & ANCILLARIES		1	30.00	-67,884
8.00		OPERATING ROOM		1	50.00	778
9.00		IV THERAPY		1	64.00	67,106

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/22/2022 9:17 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	8,632,093		8,632,093	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,405,652		3,405,652	0	0	50.00
53.00	05300	ANESTHESIOLOGY	211,753		211,753	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,447,445		4,447,445	0	0	54.00
60.00	06000	LABORATORY	4,383,564		4,383,564	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	818,680		818,680	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,181,572	0	1,181,572	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,458,138	0	2,458,138	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	850,088	0	850,088	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	294,041	0	294,041	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	394,421		394,421	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,076		229,076	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	378,612		378,612	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,048,068		4,048,068	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	751,128		751,128	0	0	76.00
76.01	03950	DIABETIC EDUCATION	11,599		11,599	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,786,970		6,786,970	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	538,526		538,526		0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,821,426	0	39,821,426	0	0	200.00
201.00		Less Observation Beds	538,526		538,526			201.00
202.00		Total (see instructions)	39,282,900	0	39,282,900	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/22/2022 9:17 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	7,146,798		7,146,798			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	237,568	4,947,114	5,184,682	0.656868	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	17,862	691,470	709,332	0.298525	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,825	41,645,843	43,347,668	0.102599	0.000000	54.00
60.00	06000	LABORATORY	2,760,973	13,442,353	16,203,326	0.270535	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	72,245	2,017,462	2,089,707	0.391768	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	976,537	2,142,227	3,118,764	0.378859	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	919,739	4,109,430	5,029,169	0.488776	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	956,563	865,261	1,821,824	0.466614	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	308,547	627,470	936,017	0.314141	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	139,504	2,217,547	2,357,051	0.167337	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	784,195	696,722	1,480,917	0.154685	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180,603	1,557,884	1,738,487	0.217782	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,751,278	9,486,383	13,237,661	0.305799	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	955,286	955,286	0.786286	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	32,574	32,574	0.356082	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	466,560	16,397,156	16,863,716	0.402460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,165	1,652,407	1,657,572	0.324888	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,425,962	103,484,589	123,910,551			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,425,962	103,484,589	123,910,551			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/22/2022 9:17 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
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
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/22/2022 9:17 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	954,217	5,184,682	0.184045	155,406	28,602
53.00	05300	ANESTHESIOLOGY	56,515	709,332	0.079674	16,569	1,320
54.00	05400	RADIOLOGY-DIAGNOSTIC	758,212	43,347,668	0.017491	669,071	11,703
60.00	06000	LABORATORY	478,773	16,203,326	0.029548	958,344	28,317
64.00	06400	INTRAVENOUS THERAPY	146,606	2,089,707	0.070156	1,339	94
65.00	06500	RESPIRATORY THERAPY	106,709	3,118,764	0.034215	291,039	9,958
66.00	06600	PHYSICAL THERAPY	310,508	5,029,169	0.061741	59,550	3,677
67.00	06700	OCCUPATIONAL THERAPY	137,211	1,821,824	0.075315	59,921	4,513
68.00	06800	SPEECH PATHOLOGY	14,498	936,017	0.015489	39,753	616
69.00	06900	ELECTROCARDIOLOGY	86,533	2,357,051	0.036712	45,023	1,653
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,855	1,480,917	0.012057	258,938	3,122
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,510	1,738,487	0.016975	180,603	3,066
73.00	07300	DRUGS CHARGED TO PATIENTS	409,553	13,237,661	0.030938	1,111,184	34,378
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	123,231	955,286	0.128999	0	0
76.01	03950	DIABETIC EDUCATION	399	32,574	0.012249	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	675,916	16,863,716	0.040081	2,213	89
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,433	1,657,572	0.052748	0	0
200.00		Total (lines 50 through 199)	4,393,679	116,763,753		3,848,953	131,108

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description			Title XVIII		Hospital		Cost
			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
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
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	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: 14-1339

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

Worksheet D
Part IV
Date/Time Prepared:
2/22/2022 9:17 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	5,184,682	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	709,332	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,347,668	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,203,326	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,089,707	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,118,764	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,029,169	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,821,824	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	936,017	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,357,051	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,480,917	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,738,487	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,237,661	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	955,286	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	32,574	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	16,863,716	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,657,572	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	116,763,753		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1339

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

Worksheet D
Part IV
Date/Time Prepared:
2/22/2022 9:17 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	155,406	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	16,569	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	669,071	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	958,344	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,339	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	291,039	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	59,550	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	59,921	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	39,753	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	45,023	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	258,938	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	180,603	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,111,184	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
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	2,213	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)		3,848,953	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/22/2022 9:17 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	0.656868	0	2,120,961	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.298525	0	259,266	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102599	0	13,690,565	0	0	54.00	
60.00	06000	LABORATORY	0.270535	0	4,320,201	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.391768	0	957,620	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.378859	0	694,183	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.488776	0	1,272,750	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.466614	0	175,307	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.314141	0	66,972	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.167337	0	894,515	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154685	0	246,695	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217782	0	642,069	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305799	0	5,891,511	363	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786286	0	617,536	0	0	76.00	
76.01	03950	DIABETIC EDUCATION	0.356082	0	3,150	0	0	76.01	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.402460	0	4,256,780	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.324888	0	623,674	0	0	92.00	
200.00		Subtotal (see instructions)		0	36,733,755	363	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	36,733,755	363	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1339		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Prepared: 2/22/2022 9:17 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	1,393,191	0		50.00
53.00	05300	ANESTHESIOLOGY	77,397	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,404,638	0		54.00
60.00	06000	LABORATORY	1,168,766	0		60.00
64.00	06400	INTRAVENOUS THERAPY	375,165	0		64.00
65.00	06500	RESPIRATORY THERAPY	262,997	0		65.00
66.00	06600	PHYSICAL THERAPY	622,090	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	81,801	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,039	0		68.00
69.00	06900	ELECTROCARDIOLOGY	149,685	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,160	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	139,831	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,801,618	111		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	485,560	0		76.00
76.01	03950	DIABETIC EDUCATION	1,122	0		76.01
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,713,184	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,624	0		92.00
200.00		Subtotal (see instructions)	9,938,868	111		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,938,868	111		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/22/2022 9:17 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)		6,212	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,498	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)		2,123	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		916	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)		2,570	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		11	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)		217	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,218	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)		564	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)		1,969	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)		8,632,093	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)		1,867	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)		36,827	25.00	
26.00	Total swing-bed cost (see instructions)		5,044,799	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,587,294	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)		3,587,294	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)		1,436.06	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,749,121	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,749,121	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1339

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

Worksheet D-1

Date/Time Prepared:
2/22/2022 9:17 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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,042,892	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,792,013	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)					809,938	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					2,827,602	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					3,637,540	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)					375	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,436.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					538,526	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1339

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

Worksheet D-1

Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,401,473	8,632,093	0.162356	538,526	87,433	90.00
91.00	Nursing Program cost	0	8,632,093	0.000000	538,526	0	91.00
92.00	Allied health cost	0	8,632,093	0.000000	538,526	0	92.00
93.00	All other Medical Education	0	8,632,093	0.000000	538,526	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/22/2022 9:17 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		2,084,652		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.656868	155,406	102,081	50.00
53.00	05300	ANESTHESIOLOGY	0.298525	16,569	4,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102599	669,071	68,646	54.00
60.00	06000	LABORATORY	0.270535	958,344	259,266	60.00
64.00	06400	INTRAVENOUS THERAPY	0.391768	1,339	525	64.00
65.00	06500	RESPIRATORY THERAPY	0.378859	291,039	110,263	65.00
66.00	06600	PHYSICAL THERAPY	0.488776	59,550	29,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466614	59,921	27,960	67.00
68.00	06800	SPEECH PATHOLOGY	0.314141	39,753	12,488	68.00
69.00	06900	ELECTROCARDIOLOGY	0.167337	45,023	7,534	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154685	258,938	40,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217782	180,603	39,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305799	1,111,184	339,799	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786286	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.356082	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.402460	2,213	891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.324888	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,848,953	1,042,892	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)		3,848,953		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1339 Component CCN: 14-Z339	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/22/2022 9:17 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.656868	26,530	17,427	50.00
53.00	05300 ANESTHESIOLOGY	0.298525	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102599	319,189	32,748	54.00
60.00	06000 LABORATORY	0.270535	698,694	189,021	60.00
64.00	06400 INTRAVENOUS THERAPY	0.391768	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.378859	368,536	139,623	65.00
66.00	06600 PHYSICAL THERAPY	0.488776	575,387	281,235	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.466614	593,398	276,888	67.00
68.00	06800 SPEECH PATHOLOGY	0.314141	178,921	56,206	68.00
69.00	06900 ELECTROCARDIOLOGY	0.167337	15,774	2,640	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.154685	225,594	34,896	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.217782	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305799	608,091	185,954	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786286	0	0	76.00
76.01	03950 DIABETIC EDUCATION	0.356082	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.402460	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.324888	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,610,114	1,216,638	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,610,114		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/22/2022 9:17 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9,938,979 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)			9,938,979 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 charge basis 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)			10,038,369 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)			45,294 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			6,363,234 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)			3,629,841 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)			3,629,841 30.00
31.00	Primary payer payments			176 31.00
32.00	Subtotal (line 30 minus line 31)			3,629,665 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)			880,843 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			572,548 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			652,658 36.00
37.00	Subtotal (see instructions)			4,202,213 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)			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)			4,202,213 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			40.03
41.00	Interim payments			3,253,905 41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)			948,308 43.00
43.01	Balance due provider/program-PARHM (see instructions)			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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/22/2022 9:17 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		2,851,004		4,226,164	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	05/25/2021	325,933	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	05/25/2021	184,907	08/30/2021	1,298,192	3.50
3.51		08/30/2021	7,246		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)		-192,153		-972,259	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)		2,658,851		3,253,905	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		948,308	6.01
6.02	SETTLEMENT TO PROGRAM		114,470		0	6.02
7.00	Total Medicare program liability (see instructions)		2,544,381		4,202,213	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: 14-1339

Period:

Worksheet E-1

Component CCN: 14-Z339

From 10/01/2020

Part I

To 09/30/2021

Date/Time Prepared:

2/22/2022 9:17 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		5,181,583		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	05/25/2021	19,640		0	3.50
3.51		08/30/2021	24,206		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)		-43,846		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)		5,137,737		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		329,550		0	6.02
7.00	Total Medicare program liability (see instructions)		4,808,187		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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/22/2022 9:17 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: 14-1339

Period:

Worksheet E-2

Component CCN: 14-Z339

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/22/2022 9:17 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)		3,673,915	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)		1,228,804	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		2,533	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)		4,902,719	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		4,902,719	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)		4,902,719	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		96,743	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		4,805,976	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)		3,401	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		2,211	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		4,808,187	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		5,137,737	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)		-329,550	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: 14-1339	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/22/2022 9:17 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,792,013	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)		2,792,013	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,819,933	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)		2,819,933	19.00
20.00	Deductibles (exclude professional component)		308,068	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,511,865	22.00
23.00	Coinsurance		5,565	23.00
24.00	Subtotal (line 22 minus line 23)		2,506,300	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		58,586	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		38,081	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,676	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,544,381	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)		2,544,381	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		2,658,851	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)		-114,470	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: 14-1339

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

Worksheet G

Date/Time Prepared:
2/22/2022 9:17 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	1,896,950	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	9,538,562	0	0	0	3.00
4.00 Accounts receivable	0	0	0	0	4.00
5.00 Other receivable	541,450	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-2,399,721	0	0	0	6.00
7.00 Inventory	478,944	0	0	0	7.00
8.00 Prepaid expenses	347,465	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	489,118	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	10,892,768	0	0	0	11.00
FIXED ASSETS					
12.00 Land	948,070	0	0	0	12.00
13.00 Land improvements	4,817,396	0	0	0	13.00
14.00 Accumulated depreciation	-2,254,874	0	0	0	14.00
15.00 Buildings	16,933,351	0	0	0	15.00
16.00 Accumulated depreciation	-13,460,070	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	26,075,894	0	0	0	23.00
24.00 Accumulated depreciation	-23,577,893	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	52,918,299	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	62,400,173	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	43,734,415	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	5,067,545	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	48,801,960	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	122,094,901	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,678,328	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,008,869	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	611,217	0	0	0	40.00
41.00 Deferred income	6,807,456	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	432,078	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	12,537,948	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	14,560,510	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)	14,560,510	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	27,098,458	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	94,996,443	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)	94,996,443	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	122,094,901	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1339

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

Worksheet G-1

Date/Time Prepared:
2/22/2022 9:17 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		80,553,247		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,436,937				2.00
3.00	Total (sum of line 1 and line 2)		94,990,184		0		3.00
4.00	INCREASE IN RESTRICTED NET ASSETS	6,259		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)		6,259		0		10.00
11.00	Subtotal (line 3 plus line 10)		94,996,443		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		94,996,443		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	INCREASE IN RESTRICTED NET ASSETS		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	Deductions (debit adjustments) (specify)		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: 14-1339

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/22/2022 9:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,985,285		2,985,285	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	4,134,478		4,134,478	5.00
6.00	Swing bed - NF	50,999		50,999	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)	7,170,762		7,170,762	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)	7,170,762		7,170,762	17.00
18.00	Ancillary services	13,062,736	87,190,890	100,253,626	18.00
19.00	Outpatient services	479,837	18,198,888	18,678,725	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	PROFESSIONAL FEES	277,375	8,913,043	9,190,418	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,990,710	114,302,821	135,293,531	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,020,189		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)		44,020,189		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1339

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

Worksheet G-3

Date/Time Prepared:
2/22/2022 9:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	135,293,531	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,361,538	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,931,993	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,020,189	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,911,804	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	12,413	6.00
7.00	Income from investments	1,159,365	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	97,135	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	9,666	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	23,960	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN INTEREST IN FOUNDATION	940,892	24.00
24.01	UNREALIZED GAIN ON INVESTMENTS	625,580	24.01
24.02	MISCELLANEOUS INCOME	64,691	24.02
24.50	COVID-19 PHE Funding	591,431	24.50
25.00	Total other income (sum of lines 6-24)	3,525,133	25.00
26.00	Total (line 5 plus line 25)	14,436,937	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,436,937	29.00