

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).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN:14-4013
AND SETTLEMENT SUMMARY

Period:
From 05/01/2020
To 04/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
7/28/2021 5:08 pm

PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically prepared cost report Date: 7/28/2021 Time: 5:08 pm
2. ☐ Manually prepared cost report
3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report
4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. ☐ Cost Report Status 6. Date Received: 10. NPR Date:
(1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. ☐ Initial Report for this Provider CCN 12. ☐ If line 5, column 1 is 4: Enter
(3) Settled with Audit 9. ☐ Final Report for this Provider CCN number of times reopened = 0-9.
(4) Reopened
(5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LINCOLN PRAIRIE (14-4013) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 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.

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

Encryption Information

ECR: Date: 7/28/2021 Time: 5:08 pm

mVAK0GdF14kEK24eLlywMXMnsFKpC0

GUVcL03a:1veYadT4pn8krOLCR8fh

Q6iw02ESJL0B15.r

PI: Date: 7/28/2021 Time: 5:08 pm

ecDhGxyvt.4:wpj6sKwFZW:0c30st0

Plg0b0i:djxhrrvfV7Xi.92pq3FTqSk

mSbj0yCojb0xBAD0

(Signed)

Officer or Administrator of Provider(s)

SVP & CFO

Title

7/29/2021

Date

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	-2,718,406	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	0	0	0	-2,718,406	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

OMB NO. 0938-0050
EXPIRES 03-31-2022

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

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
7/28/2021 5:08 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 5:08 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LINCOLN PRAIRIE (14-4013) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 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.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	-2,718,406	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	0	0	0	-2,718,406	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 5:08 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5230 S 6TH ST.			PO Box:				1.00	
2.00	City: SPRINGFIELD			State: IL		Zip Code: 62703		County: SANGAMON	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LINCOLN PRAIRIE	144013	44100	4	05/15/2008	N
4.00	Subprovider - IPF								N
5.00	Subprovider - IRF								O
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2020	04/30/2021	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 5:08 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 5:08 pm	
			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 5:08 pm	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				N		112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	Y		B		0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		0118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N		118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N		122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 5:08 pm		
			1.00		2.00				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
133.00	Removed and reserved							133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00	
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)					Y	399001	140.00	
1.00			2.00			3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: UNIVERSAL HEALTH SERVICES		Contractor's Name: 399001		Contractor's Number: 399001			141.00	
142.00	Street: 367 SOUTH GULPH ROAD		PO Box: P.O. BOX		Zip Code: 19406			142.00	
143.00	City: KING OF PRUSSIA		State: PA					143.00	
							1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
							1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
							1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
			Part A	Part B	Title V	Title XIX			
			1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital		N	N	N	N		155.00	
156.00	Subprovider - IPF		N	N	N	N		156.00	
157.00	Subprovider - IRF		N	N	N	N		157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF		N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY		N	N	N	N		160.00	
161.00	CMHC			N	N	N		161.00	
161.10	CORF			N	N	N		161.10	
							1.00		
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
			Name	County	State	Zip Code	CBSA	FTE/Campus	
			0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 5:08 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 5:08 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 5:08 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y		Y	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DEANNA	SANDOVAL		41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	629-208-5506	DEANNA.SANDOVAL@UHSINC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4013	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 5:08 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	97	35,502	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		97	35,502	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		97	35,502	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		97				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	3,909	23,535		1.00
2.00	HMO and other (see instructions)	0	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,909	23,535		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	3,909	23,535	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE			0	0.00	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC	0	0	0	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	25.10
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		0	0		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	0	188	2,178	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	0	188	2,178	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet A Date/Time Prepared: 7/28/2021 5:08 pm	
Cost Center Description				Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
				1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT		960,249	960,249	0	960,249	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		178,147	178,147	-352	177,795	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	101,872	1,726,278	1,828,150	0	1,828,150	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	2,479,314	3,311,786	5,791,100	-450,211	5,340,889	5.00	
7.00	00700	OPERATION OF PLANT	153,423	705,210	858,633	0	858,633	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	159,966	159,966	0	159,966	8.00	
9.00	00900	HOUSEKEEPING	0	285,372	285,372	0	285,372	9.00	
10.00	01000	DIETARY	235,494	367,055	602,549	0	602,549	10.00	
13.00	01300	NURSING ADMINISTRATION	685,995	25,925	711,920	0	711,920	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	103,157	142,823	245,980	0	245,980	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,533,292	466,520	3,999,812	-48,139	3,951,673	30.00	
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	31,779	31,779	0	31,779	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	200,856	107,992	308,848	0	308,848	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
93.00	04950	IOP	370,314	20,075	390,389	47,162	437,551	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	27,044	6,234	33,278	977	34,255	93.99	
OTHER REIMBURSABLE COST CENTERS									
99.00	09900	CMHC	0	0	0	0	0	99.00	
99.10	09910	CORF	0	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,890,761	8,495,411	16,386,172	-450,563	15,935,609	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00	
194.01	07951	EDUCATION	110,849	2,005	112,854	0	112,854	194.01	
194.02	07952	COMMUNITY RELATIONS	0	0	0	450,563	450,563	194.02	
194.03	07953	PHP MEALS	0	0	0	0	0	194.03	
200.00		TOTAL (SUM OF LINES 118 through 199)	8,001,610	8,497,416	16,499,026	0	16,499,026	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-164,837	795,412	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,399	194,194	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-395,943	1,432,207	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,175,812	3,165,077	5.00
7.00	00700	OPERATION OF PLANT	0	858,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	159,966	8.00
9.00	00900	HOUSEKEEPING	0	285,372	9.00
10.00	01000	DIETARY	-3,545	599,004	10.00
13.00	01300	NURSING ADMINISTRATION	0	711,920	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,190	241,790	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,951,673	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	31,779	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	308,848	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	IOP	0	437,551	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	34,255	93.99
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,727,928	13,207,681	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	112,854	194.01
194.02	07952	COMMUNITY RELATIONS	0	450,563	194.02
194.03	07953	PHP MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,727,928	13,771,098	200.00

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
7/28/2021 5:08 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RENT					1.00
	ADMINISTRATIVE & GENERAL	5.00	0	352		
	0		0	352		
1.00	B - COMMUNITY RELATIONS					1.00
	COMMUNITY RELATIONS	194.02	344,891	105,672		
	0		344,891	105,672		
1.00	C - SOCIAL SERVICE					1.00
	IOP	93.00	36,029	11,133		
	2.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	957	20	
	TOTALS		36,986	11,153		
500.00	Grand Total: Increases			381,877	117,177	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RENT						1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	352	10		
	0		0	352			
1.00	B - COMMUNITY RELATIONS						1.00
	ADMINISTRATIVE & GENERAL	5.00	344,891	105,672	0		
	0		344,891	105,672			
1.00	C - SOCIAL SERVICE						1.00
	ADULTS & PEDIATRICS	30.00	36,986	11,153	0		
	2.00	0.00	0	0	0		
	TOTALS		36,986	11,153			
500.00	Grand Total: Decreases		381,877	117,177			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

		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	3,203,487	3,203,487	0	3,203,487	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	13,707,331	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	1,190,373	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	18,101,191	3,203,487	0	3,203,487	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	18,101,191	3,203,487	0	3,203,487	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,406,974	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	13,707,331	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	1,190,373	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	21,304,678	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	21,304,678	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	766,058	0	0	25,539	168,652	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	174,179	0	0	3,968	0	2.00
3.00	Total (sum of lines 1-2)	940,237	0	0	29,507	168,652	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	960,249				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	178,147				2.00
3.00	Total (sum of lines 1-2)	0	1,138,396				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,707,331	0	13,707,331	0.920097	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,190,373	0	1,190,373	0.079903	0	2.00
3.00	Total (sum of lines 1-2)	14,897,704	0	14,897,704	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	601,221	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	190,578	-352	2.00
3.00	Total (sum of lines 1-2)	0	0	0	791,799	-352	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	25,539	168,652	0	795,412	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,968	0	0	194,194	2.00
3.00	Total (sum of lines 1-2)	0	29,507	168,652	0	989,606	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-30,364	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,223,775			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	-252,465			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-3,545	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,190	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-164,837	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	16,399	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC ADMIN REVENUE	B	-12,593	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	REBATES - ADD BACK	A	30,364	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN BILLING	A	-109,743	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	HOSPITAL PAID MALPRACTICE	A	-11,808	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	LOBBYING	A	-13,315	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	BAD DEBTS	A	-150,271	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	DONATIONS	A	-839	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	PATIENT TRANSPORTATION	A	-200,693	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	EMPLOYED PHYSICIAN BENEFITS	A	-317,218	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	GAIN/LOSS ON DISPOSAL	A	0	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	STATE INCOME TAX	A	-279,035	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	SPOUSAL TRAVEL	A	0	ADMINISTRATIVE & GENERAL	5.00	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,727,928				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 5:08 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	640,844	807,600 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	INTERCO INTEREST	0	-189,085 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	116,588	195,313 3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	NRO MGMT FEE	4,585	5,827 3.01
4.00		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	0	194,827 4.00
5.00	0				762,017	1,014,482 5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 5:08 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-166,756	0		1.00
2.00	189,085	0		2.00
3.00	-78,725	0		3.00
3.01	-1,242	0		3.01
4.00	-194,827	0		4.00
5.00	-252,465			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	HEALTH CARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 5:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,223,775	1,223,775	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,223,775	1,223,775	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,223,775		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,223,775		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	795,412	795,412			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	194,194	194,194			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,432,207	3,248	793	1,436,248	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,165,077	84,103	20,533	388,059	5.00
7.00	00700	OPERATION OF PLANT	858,633	124,777	30,463	27,894	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	159,966	2,296	560	0	8.00
9.00	00900	HOUSEKEEPING	285,372	4,863	1,187	0	9.00
10.00	01000	DIETARY	599,004	31,432	7,674	42,815	10.00
13.00	01300	NURSING ADMINISTRATION	711,920	6,496	1,586	124,721	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,790	9,208	2,248	18,755	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,951,673	481,471	117,549	635,660	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	31,779	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	308,848	0	0	36,518	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	437,551	28,473	6,952	73,877	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	34,255	15,066	3,678	5,091	93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,207,681	791,433	193,223	1,353,390	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	112,854	2,177	531	20,153	194.01
194.02	07952	COMMUNITY RELATIONS	450,563	1,802	440	62,705	194.02
194.03	07953	PHP MEALS	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,771,098	795,412	194,194	1,436,248	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,657,772					5.00
7.00	00700	OPERATION OF PLANT	376,784	1,418,551				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,889	5,583	227,294			8.00
9.00	00900	HOUSEKEEPING	105,401	11,827	0	408,650		9.00
10.00	01000	DIETARY	246,276	76,443	0	22,295	1,025,939	10.00
13.00	01300	NURSING ADMINISTRATION	305,518	15,797	0	4,607	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,377	22,393	0	6,531	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,875,793	1,170,943	227,294	341,513	970,816	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	11,494	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,911	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	197,785	69,248	0	20,196	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	21,010	36,640	0	10,686	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,422,238	1,408,874	227,294	405,828	970,816	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	49,085	5,293	0	1,544	0	194.01
194.02	07952	COMMUNITY RELATIONS	186,449	4,384	0	1,278	0	194.02
194.03	07953	PHP MEALS	0	0	0	0	55,123	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,657,772	1,418,551	227,294	408,650	1,025,939	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description			NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	1,170,645					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	399,302				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,170,645	356,012	11,299,369	0	11,299,369	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	1,366	44,639	0	44,639	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,671	487,948	0	487,948	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	0	23,625	857,707	0	857,707	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	628	127,054	0	127,054	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,170,645	399,302	12,816,717	0	12,816,717	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	191,637	0	191,637	194.01
194.02	07952	COMMUNITY RELATIONS	0	0	707,621	0	707,621	194.02
194.03	07953	PHP MEALS	0	0	55,123	0	55,123	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,170,645	399,302	13,771,098	0	13,771,098	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,248	793	4,041	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,362	84,103	20,533	121,998	5.00
7.00	00700	OPERATION OF PLANT	0	124,777	30,463	155,240	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,296	560	2,856	8.00
9.00	00900	HOUSEKEEPING	0	4,863	1,187	6,050	9.00
10.00	01000	DIETARY	0	31,432	7,674	39,106	10.00
13.00	01300	NURSING ADMINISTRATION	0	6,496	1,586	8,082	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,208	2,248	11,456	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	481,471	117,549	599,020	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	0	28,473	6,952	35,425	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	15,066	3,678	18,744	93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,362	791,433	193,223	1,002,018	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	0	2,177	531	2,708	194.01
194.02	07952	COMMUNITY RELATIONS	0	1,802	440	2,242	194.02
194.03	07953	PHP MEALS	0	0	0	0	194.03
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)	17,362	795,412	194,194	1,006,968	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2021 5:08 pm

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	123,091					5.00
7.00	00700	OPERATION OF PLANT	12,679	167,998				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,982	661	5,499			8.00
9.00	00900	HOUSEKEEPING	3,547	1,401	0	10,998		9.00
10.00	01000	DIETARY	8,288	9,053	0	600	57,168	10.00
13.00	01300	NURSING ADMINISTRATION	10,281	1,871	0	124	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,311	2,652	0	176	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,124	138,674	5,499	9,190	54,096	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	387	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,203	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	6,656	8,201	0	544	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	707	4,339	0	288	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,165	166,852	5,499	10,922	54,096	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	1,652	627	0	42	0	194.01
194.02	07952	COMMUNITY RELATIONS	6,274	519	0	34	0	194.02
194.03	07953	PHP MEALS	0	0	0	0	3,072	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	123,091	167,998	5,499	10,998	57,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description			NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	20,709					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,648				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,709	15,735	907,832	0	907,832	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	60	447	0	447	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	781	5,087	0	5,087	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	0	1,044	52,078	0	52,078	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	28	24,120	0	24,120	93.99
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,709	17,648	989,564	0	989,564	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	5,086	0	5,086	194.01
194.02	07952	COMMUNITY RELATIONS	0	0	9,246	0	9,246	194.02
194.03	07953	PHP MEALS	0	0	3,072	0	3,072	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,709	17,648	1,006,968	0	1,006,968	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	93,555				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		93,555			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	382	382	7,899,738		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,892	9,892	2,134,423	-3,657,772	5.00
7.00	00700	OPERATION OF PLANT	14,676	14,676	153,423	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	270	270	0	0	8.00
9.00	00900	HOUSEKEEPING	572	572	0	0	9.00
10.00	01000	DIETARY	3,697	3,697	235,494	0	10.00
13.00	01300	NURSING ADMINISTRATION	764	764	685,995	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,083	1,083	103,157	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,630	56,630	3,496,306	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	31,779	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	200,856	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	3,349	3,349	406,343	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,772	1,772	28,001	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,087	93,087	7,443,998	-3,657,772	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	256	256	110,849	0	194.01
194.02	07952	COMMUNITY RELATIONS	212	212	344,891	0	194.02
194.03	07953	PHP MEALS	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	795,412	194,194	1,436,248	3,657,772	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.502079	2.075720	0.181810	0.361678	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,041	123,091	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000512	0.012171	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS)	NURSING ADMINISTRATION (PT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	68,605				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	270	23,535			8.00
9.00	00900	HOUSEKEEPING	572	0	67,763		9.00
10.00	01000	DIETARY	3,697	0	3,697	83,139	10.00
13.00	01300	NURSING ADMINISTRATION	764	0	764	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,083	0	1,083	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,630	23,535	56,630	78,672	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	3,349	0	3,349	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,772	0	1,772	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,137	23,535	67,295	78,672	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	256	0	256	0	194.01
194.02	07952	COMMUNITY RELATIONS	212	0	212	0	194.02
194.03	07953	PHP MEALS	0	0	0	4,467	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,418,551	227,294	408,650	1,025,939	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.677079	9.657701	6.030577	12.340045	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	167,998	5,499	10,998	57,168	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.448772	0.233652	0.162301	0.687620	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		38,539,263	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		1,705,531	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
93.00	04950	IOP	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
		60,592	
OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
		0	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		38,539,263	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	COMMUNITY RELATIONS	194.02
194.03	07953	PHP MEALS	194.03
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
		399,302	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.010361	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		17,648	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000458	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

				Title XVIII		Hospital			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,299,369		11,299,369	0	0	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00	
60.00	06000	LABORATORY	44,639		44,639	0	0	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	487,948		487,948	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
93.00	04950	IOP	857,707		857,707	0	0	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	127,054		127,054	0	0	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0		0		0	99.00	
99.10	09910	CORF	0		0		0	99.10	
200.00		Subtotal (see instructions)	12,816,717	0	12,816,717	0	0	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	12,816,717	0	12,816,717	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

					Title XVIII	Hospital		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,361,100		34,361,100			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	131,751	78	131,829	0.338613	0.000000	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,705,531	0	1,705,531	0.286097	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
93.00	04950	IOP	0	2,280,211	2,280,211	0.376152	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	60,592	60,592	2.096877	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	36,198,382	2,340,881	38,539,263			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,198,382	2,340,881	38,539,263			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-4013	Period: From 05/01/2020 To 04/30/2021	Worksheet C Part I Date/Time Prepared: 7/28/2021 5:08 pm
				Title XVIII	Hospital	
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
93.00	04950	IOP	0.000000			93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
	OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

			Title XIX		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,299,369		11,299,369	0	11,299,369	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00	
60.00	06000	LABORATORY	44,639		44,639	0	44,639	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	487,948		487,948	0	487,948	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
93.00	04950	IOP	857,707		857,707	0	857,707	93.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	127,054		127,054	0	127,054	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0		0		0	99.00	
99.10	09910	CORF	0		0		0	99.10	
200.00		Subtotal (see instructions)	12,816,717	0	12,816,717	0	12,816,717	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	12,816,717	0	12,816,717	0	12,816,717	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

					Title XIX	Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,361,100		34,361,100			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	131,751	78	131,829	0.338613	0.000000	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,705,531	0	1,705,531	0.286097	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
93.00	04950	IOP	0	2,280,211	2,280,211	0.376152	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	60,592	60,592	2.096877	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	36,198,382	2,340,881	38,539,263			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,198,382	2,340,881	38,539,263			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
93.00	04950 IOP	0.000000			93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
99.10	09910 CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
7/28/2021 5:08 pm

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,535	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,535	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)	23,535	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,909	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,299,369	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,299,369	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)	11,299,369	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)	480.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,876,750	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)	1,876,750	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,876,750	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4013		Period: From 05/01/2020 To 04/30/2021		Worksheet D-1 Date/Time Prepared: 7/28/2021 5:08 pm	
		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	907,832	11,299,369	0.080344	0	0	90.00
91.00	Nursing School cost	0	11,299,369	0.000000	0	0	91.00
92.00	Allied health cost	0	11,299,369	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,299,369	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4013	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 7/28/2021 5:08 pm	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,056,245		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.338613	0	0	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.286097	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 IOP	0.376152	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	2.096877	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4013	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 7/28/2021 5:08 pm
		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	1,876,750		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,876,750	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,876,750	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	6,056,245		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	6,056,245	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	6,056,245	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,179,495	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,876,750	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,876,750	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,876,750	0	31.00
32.00	Deductibles	0		32.00
33.00	Coinurance	0		33.00
34.00	Allowable bad debts (see instructions)	0		34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,876,750	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00
38.00	Subtotal (line 36 ± line 37)	1,876,750	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,876,750	0	40.00
41.00	Interim payments	4,595,156	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,718,406	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet G

Date/Time Prepared:
7/28/2021 5:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-44,505	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,200,043	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	75,446	0	0	0	7.00
8.00	Prepaid expenses	64,233	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,295,217	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,203,487	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	14,948,454	0	0	0	15.00
16.00	Accumulated depreciation	-7,715,441	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,449,002	0	0	0	23.00
24.00	Accumulated depreciation	-993,976	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,891,526	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,412,443	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,412,443	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,599,186	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	330,243	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,149,616	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-134,752,884	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-133,273,025	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-133,273,025	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	150,872,210				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	150,872,210	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,599,185	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-1

Date/Time Prepared:
7/28/2021 5:08 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		134,683,635		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,188,575				2.00
3.00	Total (sum of line 1 and line 2)		150,872,210		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		150,872,210		0		11.00
12.00	ROUNDING	2		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		150,872,208		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 5:08 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	34,361,100		34,361,100	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	34,361,100		34,361,100	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)	34,361,100		34,361,100	17.00
18.00	Ancillary services	1,837,282	78	1,837,360	18.00
19.00	Outpatient services	0	2,340,803	2,340,803	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	36,198,382	2,340,881	38,539,263	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,499,026		29.00
30.00	PROVIDER TAXES	2,624,938			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)		2,624,938		36.00
37.00	PHYSICIAN	2,952,100			37.00
38.00	BAD DEBTS	-150,271			38.00
39.00	EDUCATION	380,998			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		3,182,827		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,941,137		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-3

Date/Time Prepared:
7/28/2021 5:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	38,539,263	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,605,040	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,934,223	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,941,137	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,993,086	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	14,014	24.00
24.50	COVID-19 PHE Funding	156,021	24.50
24.51	COVID -19 PHE FUNDING STATE	19,139	24.51
24.52	COVID -19 PHE FUNDING LOCAL	6,315	24.52
25.00	Total other income (sum of lines 6-24)	195,489	25.00
26.00	Total (line 5 plus line 25)	16,188,575	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,188,575	29.00