

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet S Parts I-III Date/Time Prepared: 8/8/2019 9:05 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 8/8/2019	Time: 9:05 am
	2. ☐ Manually submitted 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 ROCHELLE COMMUNITY HOSPITAL (14-1312) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019 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) LORI GUTIERREZ

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	100,785	561,406	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	24,988	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	125,773	561,406	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 8/8/2019 9:05 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 900 NORTH 2ND STREET			PO Box:		Date Certified		Payment System (P, T, O, or N)	
2.00	City: ROCHELLE			State: IL		Zip Code: 61068		County: OGLE	
		Component Name		CCN Number	CBSA Number	Provider Type	Payment System (P, T, O, or N)		
							V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N O N
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N O N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2018	04/30/2019	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				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: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
8/8/2019 9:05 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					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 §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
8/8/2019 9:05 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
8/8/2019 9:05 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part I Date/Time Prepared: 8/8/2019 9:05 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	Y
					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

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	296,185	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				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)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 8/8/2019 9:05 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2018	12/31/2018		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part II Date/Time Prepared: 8/8/2019 9:05 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	
			1.00	2.00	
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.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
			Part A		Part B
			Y/N	Date	Y/N
			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)	Y	06/13/2019	Y	06/13/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
8/8/2019 9:05 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4389	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
8/8/2019 9:05 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
8/8/2019 9:05 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	13	4,745	23,256.00	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)		13	4,745	23,256.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	48.00	0	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)		17	6,205	23,304.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		17			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
8/8/2019 9:05 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	585	84	969			1.00
2.00	HMO and other (see instructions)	120	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	114	0	118			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)	699	84	1,087			7.00
8.00	INTENSIVE CARE UNIT	0	2	2			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)	699	86	1,089	0.00	276.99	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	276.99	27.00
28.00	Observation Bed Days		0	506			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: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
8/8/2019 9:05 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	218	37	374	1.00
2.00 HMO and other (see instructions)			34	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	218	37	374	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet S-10 Date/Time Prepared: 8/8/2019 9:05 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.420030 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,555,964 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,565,571		5.00
6.00	Medicaid charges	9,440,266		6.00
7.00	Medicaid cost (line 1 times line 6)	3,965,195		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	12,826		9.00
10.00	Stand-alone CHIP charges	51,065		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	21,449		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	8,623		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	5,000		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,623		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	746,308	328,458	1,074,766 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	313,472	328,458	641,930 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	313,472	328,458	641,930 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,221,861		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	534,338		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	822,057		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,399,804		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	875,679		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,517,609		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,526,232		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,081,533	1,081,533	609,218	1,690,751 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,314,974	1,314,974	-319,248	995,726 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	180,543	4,137,398	4,317,941	0	4,317,941 4.00
5.01	00570	ADMITTING	342,417	16,776	359,193	123,409	482,602 5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	507,199	396,254	903,453	0	903,453 5.02
5.03	00590	OTHER ADMIN & GENERAL	1,473,825	2,623,673	4,097,498	13,119	4,110,617 5.03
7.00	00700	OPERATION OF PLANT	323,558	857,616	1,181,174	0	1,181,174 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	63,965	63,965 8.00
9.00	00900	HOUSEKEEPING	356,209	105,243	461,452	-58,118	403,334 9.00
10.00	01000	DIETARY	277,648	318,000	595,648	-420,945	174,703 10.00
11.00	01100	CAFETERIA	0	0	0	420,945	420,945 11.00
13.00	01300	NURSING ADMINISTRATION	249,538	36,309	285,847	0	285,847 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,159	31,165	173,324	-5,847	167,477 14.00
15.00	01500	PHARMACY	225,890	1,336,816	1,562,706	-1,178,516	384,190 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461,765	123,509	585,274	0	585,274 16.00
17.00	01700	SOCIAL SERVICE	221,261	26,845	248,106	0	248,106 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,580,206	137,593	1,717,799	0	1,717,799 30.00
31.00	03100	INTENSIVE CARE UNIT	896	15,146	16,042	0	16,042 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	815,072	581,514	1,396,586	0	1,396,586 50.00
53.00	05300	ANESTHESIOLOGY	0	228,410	228,410	0	228,410 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,550	1,310,611	2,122,161	-64,423	2,057,738 54.00
60.00	06000	LABORATORY	798,167	962,672	1,760,839	-5,484	1,755,355 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	49,926	49,926	7,337	57,263 62.00
64.00	06400	INTRAVENOUS THERAPY	213,834	16,420	230,254	-178	230,076 64.00
65.00	06500	RESPIRATORY THERAPY	12,000	936,711	948,711	-27,373	921,338 65.00
66.00	06600	PHYSICAL THERAPY	0	727,248	727,248	-123,347	603,901 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	123,347	123,347 67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,201	11,201	0	11,201 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	167,748	167,748	0	167,748 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,243,117	1,243,117 73.00
76.00	03950	DIABETIC SERVICES	39,966	830	40,796	0	40,796 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,369,247	1,465,911	2,835,158	-1,853	2,833,305 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		225,830	225,830	-225,830	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,402,950	19,243,882	29,646,832	173,295	29,820,127 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
194.00	07950	OCCUPATIONAL HEALTH	272,226	132,805	405,031	0	405,031 194.00
194.01	07951	FOUNDATION	0	0	0	0	0 194.01
194.02	07952	PHYSICIANS CLINICS	162,983	7,292	170,275	-170,275	0 194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,425,113	292,943	1,718,056	-3,020	1,715,036 194.03
194.04	07954	340B PHARMACY	0	0	0	0	0 194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,263,272	19,676,922	31,940,194	0	31,940,194 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-225,830	1,464,921	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-121,933	873,793	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-27,099	4,290,842	4.00
5.01	00570	ADMITTING	0	482,602	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	903,453	5.02
5.03	00590	OTHER ADMIN & GENERAL	-1,072,670	3,037,947	5.03
7.00	00700	OPERATION OF PLANT	-626	1,180,548	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,965	8.00
9.00	00900	HOUSEKEEPING	0	403,334	9.00
10.00	01000	DIETARY	0	174,703	10.00
11.00	01100	CAFETERIA	-89,585	331,360	11.00
13.00	01300	NURSING ADMINISTRATION	-5,667	280,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,922	164,555	14.00
15.00	01500	PHARMACY	-15,469	368,721	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,903	578,371	16.00
17.00	01700	SOCIAL SERVICE	0	248,106	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,717,799	30.00
31.00	03100	INTENSIVE CARE UNIT	0	16,042	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-22,500	1,374,086	50.00
53.00	05300	ANESTHESIOLOGY	-226,131	2,279	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,057,738	54.00
60.00	06000	LABORATORY	0	1,755,355	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	57,263	62.00
64.00	06400	INTRAVENOUS THERAPY	-200	229,876	64.00
65.00	06500	RESPIRATORY THERAPY	0	921,338	65.00
66.00	06600	PHYSICAL THERAPY	-64,476	539,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	123,347	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	167,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,243,117	73.00
76.00	03950	DIABETIC SERVICES	0	40,796	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,097,274	1,736,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,979,285	26,840,842	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	405,031	194.00
194.01	07951	FOUNDATION	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,715,036	194.03
194.04	07954	340B PHARMACY	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,979,285	28,960,909	200.00

RECLASSIFICATIONS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-6

Date/Time Prepared:
8/8/2019 9:05 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	64,140		1.00
2.00		0.00	0	0		2.00
	0		0	64,140		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	196,214	224,731		1.00
	0		196,214	224,731		
	C - RECEPTIONIST-NURSING					
1.00	ADMITTING	5.01	118,124	5,285		1.00
2.00	RESPIRATORY THERAPY	65.00	44,859	2,007		2.00
	0		162,983	7,292		
	D - FITNESS CENTER					
1.00	OTHER ADMIN & GENERAL	5.03	0	74,239		1.00
	0		0	74,239		
	E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	225,830		1.00
	0		0	225,830		
	F - EKGS					
1.00	LABORATORY	60.00	1,853	0		1.00
	0		1,853	0		
	G - FIXED EQUIPMENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	339,448		1.00
	0		0	339,448		
	H - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	123,347		1.00
	0		0	123,347		
	I - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	63,965		1.00
2.00		0.00	0	0		2.00
	0		0	63,965		
	J - PHYSICIAN ADMIN COSTS					
1.00	OTHER ADMIN & GENERAL	5.03	3,020	0		1.00
	0		3,020	0		
	K - BLOOD BANK SALARIES					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	7,337	0		1.00
	0		7,337	0		
	L - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,243,117		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	1,243,117		
500.00	Grand Total: Increases		371,407	2,366,109		500.00

RECLASSIFICATIONS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-6

Date/Time Prepared:
8/8/2019 9:05 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.03	0	64,140	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	64,140			
	B - CAFETERIA						
1.00	DIETARY	10.00	196,214	224,731	0		1.00
	0		196,214	224,731			
	C - RECEPTIONIST-NURSING						
1.00	PHYSICIANS CLINICS	194.02	162,983	7,292	0		1.00
2.00		0.00	0	0	0		2.00
	0		162,983	7,292			
	D - FITNESS CENTER						
1.00	RESPIRATORY THERAPY	65.00	0	74,239	0		1.00
	0		0	74,239			
	E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	225,830	11		1.00
	0		0	225,830			
	F - EKGS						
1.00	EMERGENCY	91.00	1,853	0	0		1.00
	0		1,853	0			
	G - FIXED EQUIPMENT						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	339,448	9		1.00
	0		0	339,448			
	H - OCCUPATIONAL THERAPY						
1.00	PHYSICAL THERAPY	66.00	0	123,347	0		1.00
	0		0	123,347			
	I - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	58,118	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,847	0		2.00
	0		0	63,965			
	J - PHYSICIAN ADMIN COSTS						
1.00	HEALTH & WELLNESS CENTER	194.03	3,020	0	0		1.00
	0		3,020	0			
	K - BLOOD BANK SALARIES						
1.00	LABORATORY	60.00	7,337	0	0		1.00
	0		7,337	0			
	L - DRUG COSTS						
1.00	PHARMACY	15.00	0	1,178,516	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	64,423	0		2.00
3.00	INTRAVENOUS THERAPY	64.00	0	178	0		3.00
	TOTALS		0	1,243,117			
500.00	Grand Total: Decreases		371,407	2,366,109			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part I
Date/Time Prepared:
8/8/2019 9:05 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,684,161	0	0	0	0	1.00	
2.00	Land Improvements	1,470,052	14,595	0	14,595	20,810	2.00	
3.00	Buildings and Fixtures	20,765,822	87,522	0	87,522	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	3,019,344	336,953	0	336,953	19,931	5.00	
6.00	Movable Equipment	9,596,399	641,794	0	641,794	320,826	6.00	
7.00	HIT designated Assets	3,868,112	0	0	0	298,194	7.00	
8.00	Subtotal (sum of lines 1-7)	42,403,890	1,080,864	0	1,080,864	659,761	8.00	
9.00	Reconciling Items	0	-661,925	0	-661,925	0	9.00	
10.00	Total (line 8 minus line 9)	42,403,890	1,742,789	0	1,742,789	659,761	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,684,161	0					1.00
2.00	Land Improvements	1,463,837	0					
3.00	Buildings and Fixtures	20,853,344	0					
4.00	Building Improvements	0	0					
5.00	Fixed Equipment	3,336,366	0					
6.00	Movable Equipment	9,917,367	0					
7.00	HIT designated Assets	3,569,918	0					
8.00	Subtotal (sum of lines 1-7)	42,824,993	0					
9.00	Reconciling Items	-661,925	0					
10.00	Total (line 8 minus line 9)	43,486,918	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part II
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,064,432	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,314,974	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,379,406	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	17,101	1,081,533				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,314,974				2.00
3.00	Total (sum of lines 1-2)	17,101	2,396,507				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part III
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	29,337,708	0	29,337,708	0.685060	43,940	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,487,285	0	13,487,285	0.314940	20,200	2.00
3.00	Total (sum of lines 1-2)	42,824,993	0	42,824,993	1.000000	64,140	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	43,940	1,403,880	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,200	853,593	0	2.00
3.00	Total (sum of lines 1-2)	0	0	64,140	2,257,473	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	43,940	0	17,101	1,464,921	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,200	0	0	873,793	2.00
3.00	Total (sum of lines 1-2)	0	64,140	0	17,101	2,338,714	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-225,830	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP 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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-626	OPERATION OF PLANT	7.00	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	-1,346,105			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-89,585	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-2,922	CENTRAL SERVICES & SUPPLY	14.00	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	-6,903	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-120,575	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PHYSICAL THERAPY RENTAL INCOME	B	-64,476	PHYSICAL THERAPY	66.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	CREDENTIALING	B	-10,100	OTHER ADMIN & GENERAL	5.03	0	33.01
33.02	MISC REVENUE	B	-10,095	OTHER ADMIN & GENERAL	5.03	0	33.02
33.03	FITNESS CENTER	B	-52,492	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MARKETING EXPENSE	A	-266,168	OTHER ADMIN & GENERAL	5.03	0	33.04
33.05	LOBBYING EXPENSE	A	-13,687	OTHER ADMIN & GENERAL	5.03	0	33.05
33.06	PROPERTY TAX	A	-12,747	OTHER ADMIN & GENERAL	5.03	0	33.06
33.07	ASSESSMENT TAX	A	-701,938	OTHER ADMIN & GENERAL	5.03	0	33.07
33.08	PHYSICIAN BENEFITS	A	-15,094	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.10	TELEPHONE SERVICES	A	-761	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	TELEPHONE SERVICES	A	-2,410	OTHER ADMIN & GENERAL	5.03	0	33.11
33.12	TELEPHONE SERVICES	A	-1,358	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	MARKETING BENEFITS	A	-11,619	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	MISC REVENUE - DEF COMP	B	375	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	EDUCATION MISC REVENUE	B	-5,667	NURSING ADMINISTRATION	13.00	0	33.15
33.17	DONATIONS	A	-3,033	OTHER ADMIN & GENERAL	5.03	0	33.17
33.18	340B RETAIL PHARMACY COSTS	A	-15,469	PHARMACY	15.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.19
	(3)						
33.20	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.20
	(3)						
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,979,285				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-2

Date/Time Prepared:
8/8/2019 9:05 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	22,500	22,500	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	226,131	226,131	0	0	0	2.00
3.00	64.00	INTRAVENOUS THERAPY	200	200	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	12,000	0	12,000	0	0	4.00
5.00	91.00	EMERGENCY	739,489	478,597	260,892	0	0	5.00
6.00	91.00	EMERGENCY	47,871	0	47,871	0	0	6.00
7.00	91.00	EMERGENCY	154,516	154,516	0	0	0	7.00
8.00	91.00	EMERGENCY	464,161	464,161	0	0	0	8.00
9.00	5.03	OTHER ADMIN & GENERAL	3,020	0	3,020	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,669,888	1,346,105	323,783		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	5.03	OTHER ADMIN & GENERAL	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	50.00	OPERATING ROOM	0	0	0	22,500		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	226,131		2.00
3.00	64.00	INTRAVENOUS THERAPY	0	0	0	200		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	478,597		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	91.00	EMERGENCY	0	0	0	154,516		7.00
8.00	91.00	EMERGENCY	0	0	0	464,161		8.00
9.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,346,105		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/8/2019 9:05 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	400.00	7,993.13	0.00	2,454.39	0.00	9.00
10.00	AHSEA (see instructions)	95.63	83.16	40.54	16.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.58	41.58	20.27			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					38,252	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					664,709	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					702,961	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					39,270	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					742,231	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					742,231	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					15,177	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					15,177	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,033	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					17,210	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					17,210	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/8/2019 9:05 am		
		Physical Therapy				Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.16	40.54	16.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						742,231	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						17,210	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						759,441	63.00
64.00	Total cost of outside supplier services (from your records)						560,947	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						15,177	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,033	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						17,210	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,033	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						2,033	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/8/2019 9:05 am		
				Respiratory Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.57	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	15,916.86	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	65.29	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.65	32.65	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)						12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)						13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						1,039,212	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						1,039,212	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						1,039,212	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						1,039,212	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						11,917	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						11,917	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						2,033	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						13,950	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						13,950	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/8/2019 9:05 am		
				Respiratory Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.29	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						1,039,212	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						13,950	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						1,053,162	63.00
64.00	Total cost of outside supplier services (from your records)						886,384	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						11,917	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,033	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						13,950	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,033	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						2,033	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/8/2019 9:05 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,445.38	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.41	39.41	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					113,910	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					113,910	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					113,910	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					113,910	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					14,385	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,385	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,033	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,418	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,418	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/8/2019 9:05 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.81	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					113,910	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,418	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					130,328	63.00
64.00	Total cost of outside supplier services (from your records)					114,559	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					14,385	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,033	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					16,418	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,033	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					2,033	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,464,921	1,464,921			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	873,793		873,793		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,290,842	4,573	305	4,295,720	4.00
5.01	00570	ADMITTING	482,602	8,707	1,733	167,223	660,265 5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	903,453	38,711	2,772	184,165	0 5.02
5.03	00590	OTHER ADMIN & GENERAL	3,037,947	358,903	176,360	512,326	0 5.03
7.00	00700	OPERATION OF PLANT	1,180,548	129,602	12,129	117,485	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,965	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	403,334	8,648	1,715	129,340	0 9.00
10.00	01000	DIETARY	174,703	32,994	2,493	29,569	0 10.00
11.00	01100	CAFETERIA	331,360	20,990	0	71,246	0 11.00
13.00	01300	NURSING ADMINISTRATION	280,180	16,695	1,615	90,608	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164,555	14,452	1,088	51,618	0 14.00
15.00	01500	PHARMACY	368,721	10,671	14,737	82,021	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	578,371	20,755	4,881	167,668	0 16.00
17.00	01700	SOCIAL SERVICE	248,106	2,243	0	80,340	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,717,799	121,599	60,368	573,778	32,014 30.00
31.00	03100	INTENSIVE CARE UNIT	16,042	24,405	2,959	325	34 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,374,086	110,225	246,860	295,954	59,729 50.00
53.00	05300	ANESTHESIOLOGY	2,279	0	13,556	0	8,787 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,057,738	74,006	239,406	294,675	192,794 54.00
60.00	06000	LABORATORY	1,755,355	27,190	24,706	287,825	112,280 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,263	3,166	832	2,664	1,042 62.00
64.00	06400	INTRAVENOUS THERAPY	229,876	16,270	8,701	77,571	6,537 64.00
65.00	06500	RESPIRATORY THERAPY	921,338	54,790	419	16,288	17,531 65.00
66.00	06600	PHYSICAL THERAPY	539,425	34,680	1,245	0	26,977 66.00
67.00	06700	OCCUPATIONAL THERAPY	123,347	7,212	259	0	5,612 67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,201	0	0	0	3,427 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	167,748	0	0	0	5,888 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,243,117	0	0	0	115,974 73.00
76.00	03950	DIABETIC SERVICES	40,796	1,935	0	14,512	298 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,736,031	87,638	24,365	433,308	71,341 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,840,842	1,231,060	843,504	3,680,509	660,265 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,786	0	0	0 190.00
194.00	07950	OCCUPATIONAL HEALTH	405,031	0	789	98,846	0 194.00
194.01	07951	FOUNDATION	0	0	0	0	0 194.01
194.02	07952	PHYSICIANS CLINICS	0	56,871	10,375	0	0 194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,715,036	170,204	19,125	516,365	0 194.03
194.04	07954	340B PHARMACY	0	0	0	0	0 194.04
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	28,960,909	1,464,921	873,793	4,295,720	660,265 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,129,101					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	4,085,536	4,085,536			5.03
7.00	00700	OPERATION OF PLANT	0	1,439,764	236,467	1,676,231		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,965	10,506	0	74,471	8.00
9.00	00900	HOUSEKEEPING	0	543,037	89,188	15,681	0	9.00
10.00	01000	DIETARY	0	239,759	39,378	59,827	0	10.00
11.00	01100	CAFETERIA	0	423,596	69,571	38,060	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	389,098	63,905	30,273	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	231,713	38,057	26,206	0	14.00
15.00	01500	PHARMACY	0	476,150	78,203	19,349	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	771,675	126,740	37,635	0	16.00
17.00	01700	SOCIAL SERVICE	0	330,689	54,312	4,066	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,039	2,559,597	420,388	220,492	17,977	30.00
31.00	03100	INTENSIVE CARE UNIT	57	43,822	7,197	44,253	33	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	100,820	2,187,674	359,304	199,868	9,836	50.00
53.00	05300	ANESTHESIOLOGY	14,833	39,455	6,480	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,449	3,184,068	522,956	134,193	14,514	54.00
60.00	06000	LABORATORY	189,525	2,396,881	393,664	49,302	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,758	66,725	10,959	5,741	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,034	349,989	57,482	29,502	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,592	1,039,958	170,803	99,349	0	65.00
66.00	06600	PHYSICAL THERAPY	45,536	647,863	106,405	62,884	4,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,472	145,902	23,963	13,076	884	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,784	20,412	3,352	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,939	183,575	30,150	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,760	1,554,851	255,369	0	0	73.00
76.00	03950	DIABETIC SERVICES	504	58,045	9,533	3,508	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	120,422	2,473,105	406,183	158,911	26,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,114,524	25,946,904	3,590,515	1,252,176	74,471	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,786	1,115	12,306	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	504,666	82,886	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	14,577	81,823	13,439	103,123	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,420,730	397,581	308,626	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	1,129,101	28,960,909	4,085,536	1,676,231	74,471	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1312

Period:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	647,906					9.00
10.00	01000	DIETARY	23,343	362,307				10.00
11.00	01100	CAFETERIA	14,850	0	546,077			11.00
13.00	01300	NURSING ADMINISTRATION	11,812	0	9,380	504,468		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,225	0	7,688	0	313,889	14.00
15.00	01500	PHARMACY	7,549	0	8,888	0	6,278	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,684	0	29,615	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,587	0	7,135	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	86,031	277,500	149,241	243,158	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,266	1,251	62	111	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	77,983	26,455	38,226	62,266	6,278	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,359	0	54,955	0	3,139	54.00
60.00	06000	LABORATORY	19,237	0	71,254	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,240	0	646	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,511	22,077	8,734	14,213	0	64.00
65.00	06500	RESPIRATORY THERAPY	38,764	0	1,753	2,840	0	65.00
66.00	06600	PHYSICAL THERAPY	24,536	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,102	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	109,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	188,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	1,369	0	1,753	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	62,003	35,024	111,448	181,880	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	482,451	362,307	500,778	504,468	313,889	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,801	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	40,236	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	120,418	0	45,299	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	647,906	362,307	546,077	504,468	313,889	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	596,417					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	980,349				16.00
17.00	01700	SOCIAL SERVICE	0	0	397,789			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	194,818	396,970	4,566,172	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	819	114,814	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	46,851	0	3,014,741	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	45,935	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,909	102,063	0	4,099,156	0	54.00
60.00	06000	LABORATORY	0	120,992	0	3,051,330	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	86,311	0	62.00
64.00	06400	INTRAVENOUS THERAPY	85	123,832	0	617,425	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,837	0	1,359,304	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,402	0	855,339	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,956	0	190,883	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	133,625	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	402,058	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565,423	0	0	2,375,643	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	74,208	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	374,598	0	3,830,130	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	596,417	980,349	397,789	24,817,074	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	25,008	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	587,552	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	238,621	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	3,292,654	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	596,417	980,349	397,789	28,960,909	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		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
5.01	00570	ADMITTING	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.02
5.03	00590	OTHER ADMIN & GENERAL	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OCCUPATIONAL HEALTH	194.00
194.01	07951	FOUNDATION	194.01
194.02	07952	PHYSICIANS CLINICS	194.02
194.03	07953	HEALTH & WELLNESS CENTER	194.03
194.04	07954	340B PHARMACY	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,573	305	4,878	4,878 4.00
5.01	00570	ADMITTING	0	8,707	1,733	10,440	190 5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	38,711	2,772	41,483	209 5.02
5.03	00590	OTHER ADMIN & GENERAL	0	358,903	176,360	535,263	581 5.03
7.00	00700	OPERATION OF PLANT	0	129,602	12,129	141,731	133 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	8,648	1,715	10,363	147 9.00
10.00	01000	DIETARY	0	32,994	2,493	35,487	34 10.00
11.00	01100	CAFETERIA	0	20,990	0	20,990	81 11.00
13.00	01300	NURSING ADMINISTRATION	0	16,695	1,615	18,310	103 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,452	1,088	15,540	59 14.00
15.00	01500	PHARMACY	0	10,671	14,737	25,408	93 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,755	4,881	25,636	190 16.00
17.00	01700	SOCIAL SERVICE	0	2,243	0	2,243	91 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	121,599	60,368	181,967	655 30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,405	2,959	27,364	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	110,225	246,860	357,085	336 50.00
53.00	05300	ANESTHESIOLOGY	0	0	13,556	13,556	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,006	239,406	313,412	334 54.00
60.00	06000	LABORATORY	0	27,190	24,706	51,896	327 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,166	832	3,998	3 62.00
64.00	06400	INTRAVENOUS THERAPY	0	16,270	8,701	24,971	88 64.00
65.00	06500	RESPIRATORY THERAPY	0	54,790	419	55,209	18 65.00
66.00	06600	PHYSICAL THERAPY	0	34,680	1,245	35,925	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,212	259	7,471	0 67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	DIABETIC SERVICES	0	1,935	0	1,935	16 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	87,638	24,365	112,003	492 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,231,060	843,504	2,074,564	4,180 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,786	0	6,786	0 190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	789	789	112 194.00
194.01	07951	FOUNDATION	0	0	0	0	0 194.01
194.02	07952	PHYSICIANS CLINICS	0	56,871	10,375	67,246	0 194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	170,204	19,125	189,329	586 194.03
194.04	07954	340B PHARMACY	0	0	0	0	0 194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,464,921	873,793	2,338,714	4,878 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
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
5.01	00570	ADMITTING	10,630					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	41,692				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	535,844			5.03
7.00	00700	OPERATION OF PLANT	0	0	31,014	172,878		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,378	0	1,378	8.00
9.00	00900	HOUSEKEEPING	0	0	11,698	1,617	0	9.00
10.00	01000	DIETARY	0	0	5,165	6,170	0	10.00
11.00	01100	CAFETERIA	0	0	9,125	3,925	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,382	3,122	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,991	2,703	0	14.00
15.00	01500	PHARMACY	0	0	10,257	1,996	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16,623	3,881	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	7,123	419	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	516	1,997	55,136	22,740	333	30.00
31.00	03100	INTENSIVE CARE UNIT	1	2	944	4,564	1	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	962	3,725	47,125	20,613	182	50.00
53.00	05300	ANESTHESIOLOGY	142	548	850	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,099	11,996	68,590	13,840	269	54.00
60.00	06000	LABORATORY	1,809	7,003	51,631	5,085	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17	65	1,437	592	0	62.00
64.00	06400	INTRAVENOUS THERAPY	105	408	7,539	3,043	0	64.00
65.00	06500	RESPIRATORY THERAPY	282	1,093	22,402	10,246	0	65.00
66.00	06600	PHYSICAL THERAPY	435	1,683	13,956	6,486	79	66.00
67.00	06700	OCCUPATIONAL THERAPY	90	350	3,143	1,349	16	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	214	440	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95	367	3,954	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,868	7,233	33,493	0	0	73.00
76.00	03950	DIABETIC SERVICES	5	19	1,250	362	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,149	4,450	53,273	16,389	498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,630	41,153	470,919	129,142	1,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	146	1,269	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	10,871	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	539	1,763	10,636	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	52,145	31,831	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	10,630	41,692	535,844	172,878	1,378	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	23,825					9.00
10.00	01000	DIETARY	858	47,714				10.00
11.00	01100	CAFETERIA	546	0	34,667			11.00
13.00	01300	NURSING ADMINISTRATION	434	0	595	30,946		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376	0	488	0	24,157	14.00
15.00	01500	PHARMACY	278	0	564	0	483	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	540	0	1,880	0	0	16.00
17.00	01700	SOCIAL SERVICE	58	0	453	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,164	36,546	9,476	14,916	0	30.00
31.00	03100	INTENSIVE CARE UNIT	635	165	4	7	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,868	3,484	2,427	3,820	483	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,925	0	3,489	0	242	54.00
60.00	06000	LABORATORY	707	0	4,523	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	82	0	41	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	423	2,907	554	872	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,425	0	111	174	0	65.00
66.00	06600	PHYSICAL THERAPY	902	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	188	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	50	0	111	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,280	4,612	7,075	11,157	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,739	47,714	31,791	30,946	24,157	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	177	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	1,480	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	4,429	0	2,876	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	23,825	47,714	34,667	30,946	24,157	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	39,079					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,750				16.00
17.00	01700	SOCIAL SERVICE	0	0	10,387			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,688	10,366	347,500	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	21	33,708	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,330	0	445,440	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,096	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,025	5,075	0	424,296	0	54.00
60.00	06000	LABORATORY	0	6,017	0	128,998	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,235	0	62.00
64.00	06400	INTRAVENOUS THERAPY	6	6,158	0	47,074	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	290	0	91,250	0	65.00
66.00	06600	PHYSICAL THERAPY	0	468	0	59,934	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	97	0	12,704	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,164	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,910	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,048	0	0	79,642	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	3,748	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	18,627	0	232,005	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,079	48,750	10,387	1,955,704	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,378	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	11,772	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	81,664	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	281,196	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,079	48,750	10,387	2,338,714	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Total	
		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
5.01	00570	ADMITTING	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.02
5.03	00590	OTHER ADMIN & GENERAL	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OCCUPATIONAL HEALTH	194.00
194.01	07951	FOUNDATION	194.01
194.02	07952	PHYSICIANS CLINICS	194.02
194.03	07953	HEALTH & WELLNESS CENTER	194.03
194.04	07954	340B PHARMACY	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,943					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		853,593				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312	298	11,830,609			4.00
5.01	00570	ADMITTING	594	1,693	460,541	59,084,103		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,641	2,708	507,199	0	59,856,875	5.02
5.03	00590	OTHER ADMIN & GENERAL	24,486	172,283	1,410,969	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	11,849	323,558	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	1,675	356,209	0	0	9.00
10.00	01000	DIETARY	2,251	2,435	81,434	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	196,214	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,139	1,578	249,538	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986	1,063	142,159	0	0	14.00
15.00	01500	PHARMACY	728	14,396	225,890	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	4,768	461,765	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	221,261	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,296	58,972	1,580,206	2,864,790	2,864,790	30.00
31.00	03100	INTENSIVE CARE UNIT	1,665	2,891	896	3,000	3,000	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,520	241,153	815,072	5,344,879	5,344,879	50.00
53.00	05300	ANESTHESIOLOGY	0	13,243	0	786,340	786,340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	233,871	811,550	17,252,279	17,252,279	54.00
60.00	06000	LABORATORY	1,855	24,135	792,683	10,047,460	10,047,460	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	216	813	7,337	93,211	93,211	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	8,500	213,634	584,941	584,941	64.00
65.00	06500	RESPIRATORY THERAPY	3,738	409	44,859	1,568,765	1,568,765	65.00
66.00	06600	PHYSICAL THERAPY	2,366	1,216	0	2,414,026	2,414,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	492	253	0	502,170	502,170	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	306,630	306,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	526,881	526,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,378,015	10,378,015	73.00
76.00	03950	DIABETIC SERVICES	132	0	39,966	26,706	26,706	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,979	23,802	1,193,350	6,384,010	6,384,010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,988	824,004	10,136,290	59,084,103	59,084,103	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	771	272,226	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,880	10,135	0	0	772,772	194.02
194.03	07953	HEALTH & WELLNESS CENTER	11,612	18,683	1,422,093	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	1,464,921	873,793	4,295,720	660,265	1,129,101	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.657565	1.023665	0.363102	0.011175	0.018863	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,878	10,630	41,692	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000412	0.000180	0.000697	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: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.03	5.03	7.00	8.00	9.00	
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
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL	-4,085,536	24,875,373			5.03
7.00	00700	OPERATION OF PLANT	0	1,439,764	63,068		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,965	0	106,675	8.00
9.00	00900	HOUSEKEEPING	0	543,037	590	0	62,478 9.00
10.00	01000	DIETARY	0	239,759	2,251	0	2,251 10.00
11.00	01100	CAFETERIA	0	423,596	1,432	0	1,432 11.00
13.00	01300	NURSING ADMINISTRATION	0	389,098	1,139	0	1,139 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	231,713	986	0	986 14.00
15.00	01500	PHARMACY	0	476,150	728	0	728 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	771,675	1,416	0	1,416 16.00
17.00	01700	SOCIAL SERVICE	0	330,689	153	0	153 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,559,597	8,296	25,751	8,296 30.00
31.00	03100	INTENSIVE CARE UNIT	0	43,822	1,665	47	1,665 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,187,674	7,520	14,090	7,520 50.00
53.00	05300	ANESTHESIOLOGY	0	39,455	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,184,068	5,049	20,790	5,049 54.00
60.00	06000	LABORATORY	0	2,396,881	1,855	0	1,855 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	66,725	216	0	216 62.00
64.00	06400	INTRAVENOUS THERAPY	0	349,989	1,110	0	1,110 64.00
65.00	06500	RESPIRATORY THERAPY	0	1,039,958	3,738	0	3,738 65.00
66.00	06600	PHYSICAL THERAPY	0	647,863	2,366	6,087	2,366 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	145,902	492	1,266	492 67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,412	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	183,575	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,554,851	0	0	0 73.00
76.00	03950	DIABETIC SERVICES	0	58,045	132	0	132 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	2,473,105	5,979	38,644	5,979 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,085,536	21,861,368	47,113	106,675	46,523 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,786	463	0	463 190.00
194.00	07950	OCCUPATIONAL HEALTH	0	504,666	0	0	0 194.00
194.01	07951	FOUNDATION	0	0	0	0	0 194.01
194.02	07952	PHYSICIANS CLINICS	0	81,823	3,880	0	3,880 194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,420,730	11,612	0	11,612 194.03
194.04	07954	340B PHARMACY	0	0	0	0	0 194.04
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)		4,085,536	1,676,231	74,471	647,906 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.164240	26.578154	0.698111	10.370146 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		535,844	172,878	1,378	23,825 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.021541	2.741137	0.012918	0.381334 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: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	5,793					10.00
11.00	01100	CAFETERIA	0	17,757				11.00
13.00	01300	NURSING ADMINISTRATION	0	305	209,417			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	250	0	100		14.00
15.00	01500	PHARMACY	0	289	0	2	1,243,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	963	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	232	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,437	4,853	100,941	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	20	2	46	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	423	1,243	25,848	2	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,787	0	1	64,423	54.00
60.00	06000	LABORATORY	0	2,317	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	21	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	353	284	5,900	0	178	64.00
65.00	06500	RESPIRATORY THERAPY	0	57	1,179	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	35	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	60	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,178,516	73.00
76.00	03950	DIABETIC SERVICES	0	57	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	560	3,624	75,503	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,793	16,284	209,417	100	1,243,117	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,473	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	362,307	546,077	504,468	313,889	596,417	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	62.542206	30.752774	2.408916	3,138.890000	0.479775	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,714	34,667	30,946	24,157	39,079	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.236492	1.952301	0.147772	241.570000	0.031436	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: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00590	OTHER ADMIN & GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,220	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	18,525	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,455	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,705	54.00
60.00	06000	LABORATORY	11,505	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,775	64.00
65.00	06500	RESPIRATORY THERAPY	555	65.00
66.00	06600	PHYSICAL THERAPY	894	66.00
67.00	06700	OCCUPATIONAL THERAPY	186	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	DIABETIC SERVICES	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	35,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,220	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	194.00
194.01	07951	FOUNDATION	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	194.03
194.04	07954	340B PHARMACY	0	194.04
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)	980,349	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.516509	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,750	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.522956	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/8/2019 9:05 am

			Title XVIII	Hospital	Cost			
Cost Center Description			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	4,566,172		4,566,172	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	114,814		114,814	0	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,014,741		3,014,741	0	0	50.00
53.00	05300	ANESTHESIOLOGY	45,935		45,935	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,099,156		4,099,156	0	0	54.00
60.00	06000	LABORATORY	3,051,330		3,051,330	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	86,311		86,311	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	617,425		617,425	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,359,304	0	1,359,304	0	0	65.00
66.00	06600	PHYSICAL THERAPY	855,339	0	855,339	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,883	0	190,883	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,625		133,625	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	402,058		402,058	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,375,643		2,375,643	0	0	73.00
76.00	03950	DIABETIC SERVICES	74,208		74,208	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,830,130		3,830,130	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,450,398		1,450,398		0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,267,472	0	26,267,472	0	0	200.00
201.00		Less Observation Beds	1,450,398		1,450,398		0	201.00
202.00		Total (see instructions)	24,817,074	0	24,817,074	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/8/2019 9:05 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,353,240		1,353,240		30.00
31.00	03100	INTENSIVE CARE UNIT	3,000		3,000		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	490,967	4,853,912	5,344,879	0.564043	50.00
53.00	05300	ANESTHESIOLOGY	67,202	719,138	786,340	0.058416	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,979	16,807,300	17,252,279	0.237601	54.00
60.00	06000	LABORATORY	476,879	9,570,581	10,047,460	0.303692	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,204	76,007	93,211	0.925974	62.00
64.00	06400	INTRAVENOUS THERAPY	0	584,941	584,941	1.055534	64.00
65.00	06500	RESPIRATORY THERAPY	216,130	1,352,635	1,568,765	0.866480	65.00
66.00	06600	PHYSICAL THERAPY	138,250	2,275,776	2,414,026	0.354321	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	502,170	502,170	0.380116	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,982	121,648	306,630	0.435786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	153,462	373,419	526,881	0.763091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	950,805	9,427,210	10,378,015	0.228911	73.00
76.00	03950	DIABETIC SERVICES	0	26,706	26,706	2.778701	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	6,384,010	6,384,010	0.599957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,511,550	1,511,550	0.959544	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,497,100	54,587,003	59,084,103		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,497,100	54,587,003	59,084,103		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	DIABETIC SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part II
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	445,440	5,344,879	0.083340	199,797	16,651
53.00	05300	ANESTHESIOLOGY	15,096	786,340	0.019198	29,425	565
54.00	05400	RADIOLOGY-DIAGNOSTIC	424,296	17,252,279	0.024594	324,682	7,985
60.00	06000	LABORATORY	128,998	10,047,460	0.012839	328,737	4,221
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,235	93,211	0.066891	6,224	416
64.00	06400	INTRAVENOUS THERAPY	47,074	584,941	0.080476	0	0
65.00	06500	RESPIRATORY THERAPY	91,250	1,568,765	0.058167	128,857	7,495
66.00	06600	PHYSICAL THERAPY	59,934	2,414,026	0.024827	65,058	1,615
67.00	06700	OCCUPATIONAL THERAPY	12,704	502,170	0.025298	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,164	306,630	0.029886	128,003	3,825
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,910	526,881	0.035890	90,587	3,251
73.00	07300	DRUGS CHARGED TO PATIENTS	79,642	10,378,015	0.007674	543,560	4,171
76.00	03950	DIABETIC SERVICES	3,748	26,706	0.140343	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	232,005	6,384,010	0.036342	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	110,380	1,511,550	0.073024	0	0
200.00		Total (lines 50 through 199)	1,684,876	57,727,863		1,844,930	50,195

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet D
Part IV
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
8/8/2019 9:05 am

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,344,879	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	786,340	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,252,279	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,047,460	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	93,211	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	584,941	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,568,765	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,414,026	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	502,170	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	306,630	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	526,881	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,378,015	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	26,706	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,384,010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,511,550	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	57,727,863		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	199,797	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	29,425	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	324,682	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	328,737	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	6,224	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	128,857	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	65,058	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	128,003	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	90,587	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	543,560	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,844,930	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
8/8/2019 9:05 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.564043	0	1,837,160	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.058416	0	295,849	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237601	0	5,574,559	0	0	54.00	
60.00	06000	LABORATORY	0.303692	0	3,723,083	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.925974	0	58,817	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	1.055534	0	278,520	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.866480	0	592,160	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.354321	0	714,399	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.380116	0	91,265	0	0	67.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.435786	0	54,197	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.763091	0	137,299	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228911	0	4,808,333	0	0	73.00	
76.00	03950	DIABETIC SERVICES	2.778701	0	11,060	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.599957	0	1,891,154	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.959544	0	639,632	0	0	92.00	
200.00		Subtotal (see instructions)		0	20,707,487	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	20,707,487	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
8/8/2019 9:05 am

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,036,237	0		50.00
53.00	05300	ANESTHESIOLOGY	17,282	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,324,521	0		54.00
60.00	06000	LABORATORY	1,130,671	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	54,463	0		62.00
64.00	06400	INTRAVENOUS THERAPY	293,987	0		64.00
65.00	06500	RESPIRATORY THERAPY	513,095	0		65.00
66.00	06600	PHYSICAL THERAPY	253,127	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	34,691	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,618	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,772	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,100,680	0		73.00
76.00	03950	DIABETIC SERVICES	30,732	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,134,611	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	613,755	0		92.00
200.00		Subtotal (see instructions)	7,666,242	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,666,242	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312

Period:

Worksheet D

Component CCN: 14-Z312

From 05/01/2018

Part V

To 04/30/2019

Date/Time Prepared:

8/8/2019 9:05 am

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.564043	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.058416	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237601	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.303692	0	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.925974	0	0	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	1.055534	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.866480	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.354321	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.380116	0	0	0	0	67.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.435786	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.763091	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228911	0	0	0	0	73.00	
76.00	03950	DIABETIC SERVICES	2.778701	0	0	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.599957	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.959544	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312

Period:

Worksheet D

Component CCN: 14-Z312

From 05/01/2018
To 04/30/2019Part V
Date/Time Prepared:
8/8/2019 9:05 am

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03950	DIABETIC SERVICES	0	0					76.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 8/8/2019 9:05 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,593 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,475 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)			969 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			79 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)			39 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)			585 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)			79 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)			35 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.41 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.41 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,566,172 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)			338,235 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,227,937 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,227,937 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)			2,866.40 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,676,844 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)			1,676,844 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	114,814	2	57,407.00	0	0	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)					681,194	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,358,038	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)					226,446	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					100,324	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					326,770	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)					506	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,866.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,450,398	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
8/8/2019 9:05 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	347,500	4,566,172	0.076103	1,450,398	110,380
91.00	Nursing School cost	0	4,566,172	0.000000	1,450,398	0
92.00	Allied health cost	0	4,566,172	0.000000	1,450,398	0
93.00	All other Medical Education	0	4,566,172	0.000000	1,450,398	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 8/8/2019 9:05 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		760,500		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.564043	199,797	112,694	50.00
53.00	05300	ANESTHESIOLOGY	0.058416	29,425	1,719	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237601	324,682	77,145	54.00
60.00	06000	LABORATORY	0.303692	328,737	99,835	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.925974	6,224	5,763	62.00
64.00	06400	INTRAVENOUS THERAPY	1.055534	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.866480	128,857	111,652	65.00
66.00	06600	PHYSICAL THERAPY	0.354321	65,058	23,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.380116	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.435786	128,003	55,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.763091	90,587	69,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228911	543,560	124,427	73.00
76.00	03950	DIABETIC SERVICES	2.778701	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.599957	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.959544	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,844,930	681,194	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)		1,844,930		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1312 Component CCN: 14-Z312	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 8/8/2019 9:05 am	
Cost Center Description			Title XVIII	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.564043	5,298	2,988	50.00
53.00	05300	ANESTHESIOLOGY	0.058416	1,294	76	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237601	4,502	1,070	54.00
60.00	06000	LABORATORY	0.303692	12,848	3,902	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.925974	2,992	2,771	62.00
64.00	06400	INTRAVENOUS THERAPY	1.055534	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.866480	12,807	11,097	65.00
66.00	06600	PHYSICAL THERAPY	0.354321	48,964	17,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.380116	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.435786	9,360	4,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.763091	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228911	32,832	7,516	73.00
76.00	03950	DIABETIC SERVICES	2.778701	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.599957	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.959544	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		130,897	50,848	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		130,897		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part B Date/Time Prepared: 8/8/2019 9:05 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,666,242	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,666,242	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		7,742,904	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		31,854	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,442,995	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,268,055	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,268,055	30.00
31.00	Primary payer payments		2,613	31.00
32.00	Subtotal (line 30 minus line 31)		4,265,442	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		755,587	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		491,132	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		561,657	36.00
37.00	Subtotal (see instructions)		4,756,574	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,756,574	40.00
40.01	Sequestration adjustment (see instructions)		95,131	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,100,037	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		561,406	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part I
Date/Time Prepared:
8/8/2019 9:05 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,058,557		4,100,037	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,058,557		4,100,037	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		100,785		561,406	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,159,342		4,661,443	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1312

Period:

Worksheet E-1

Component CCN: 14-Z312

From 05/01/2018
To 04/30/2019Part I
Date/Time Prepared:
8/8/2019 9:05 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		348,778		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		348,778		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		24,988		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		373,766		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet E-1 Part II Date/Time Prepared: 8/8/2019 9:05 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

Health Financial Systems		ROCHELLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet E-2	
		Component CCN: 14-Z312		Date/Time Prepared: 8/8/2019 9:05 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		330,038	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		51,356	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		114	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		381,394	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		381,394	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		381,394	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		381,394	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		381,394	0	19.00
19.01	Sequestration adjustment (see instructions)		7,628	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		348,778	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		24,988	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1312	Period: From 05/01/2018 To 04/30/2019	Worksheet E-3 Part V Date/Time Prepared: 8/8/2019 9:05 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,358,038	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,358,038	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,381,618	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,381,618	19.00
20.00	Deductibles (exclude professional component)		220,744	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,160,874	22.00
23.00	Coinsurance		670	23.00
24.00	Subtotal (line 22 minus line 23)		2,160,204	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		66,470	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		43,206	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		54,506	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,203,410	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,203,410	30.00
30.01	Sequestration adjustment (see instructions)		44,068	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		2,058,557	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		100,785	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet G

Date/Time Prepared:
8/8/2019 9:05 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	12,055,661	0	0	0	1.00
2.00	Temporary investments	12,828,455	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,304,197	0	0	0	4.00
5.00	Other receivable	402,426	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	331,187	0	0	0	7.00
8.00	Prepaid expenses	827,581	0	0	0	8.00
9.00	Other current assets	424,164	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)	31,173,671	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,684,161	0	0	0	12.00
13.00	Land improvements	1,463,837	0	0	0	13.00
14.00	Accumulated depreciation	-1,090,288	0	0	0	14.00
15.00	Buildings	20,853,344	0	0	0	15.00
16.00	Accumulated depreciation	-10,594,255	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	3,336,366	0	0	0	19.00
20.00	Accumulated depreciation	-1,626,281	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	9,917,366	0	0	0	23.00
24.00	Accumulated depreciation	-7,085,082	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	3,569,918	0	0	0	27.00
28.00	Accumulated depreciation	-3,480,999	0	0	0	28.00
29.00	Minor equipment-nondepreciable	661,925	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,610,012	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	52,938	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	52,938	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,836,621	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,191,751	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,632,826	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	525,036	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	0	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)	3,349,613	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,481,691	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	47,862	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,529,553	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,879,166	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	40,957,455				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)	40,957,455	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,836,621	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-1

Date/Time Prepared:
8/8/2019 9:05 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		38,079,784		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,877,671				2.00
3.00	Total (sum of line 1 and line 2)		40,957,455		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)		40,957,455		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,957,455		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	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/8/2019 9:05 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,211,640		1,211,640	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	136,800		136,800	5.00
6.00	Swing bed - NF	4,800		4,800	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,353,240		1,353,240	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,000		3,000	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)	3,000		3,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,356,240		1,356,240	17.00
18.00	Ancillary services	3,140,860	46,691,443	49,832,303	18.00
19.00	Outpatient services	0	7,895,560	7,895,560	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL PHYSICIAN CHARGES	0	2,150,759	2,150,759	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,497,100	56,737,762	61,234,862	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,940,194		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,940,194		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-3

Date/Time Prepared:
8/8/2019 9:05 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,234,862	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,664,771	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,570,091	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,940,194	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,629,897	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	69,309	6.00
7.00	Income from investments	328,719	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	89,585	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	6,903	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	130,999	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	432,531	24.00
24.01	MISCELLANEOUS INCOME	189,903	24.01
25.00	Total other income (sum of lines 6-24)	1,247,949	25.00
26.00	Total (line 5 plus line 25)	2,877,846	26.00
27.00	LOSS ON DISPOSAL OF ASSET	175	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	175	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,877,671	29.00