

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/20/2019 4:12 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/20/2019	Time: 4:12 pm
	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 ST. JOSEPHS HOSPITAL-HIGHLAND IL (14-1336) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-44,492	-1,087,478	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	295,583	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	251,091	-1,087,478	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: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/20/2019 4:12 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 12866 TROXLER AVENUE			PO Box:				1.00		
2.00	City: HIGHLAND			State: IL		Zip Code: 62249		County: MADISON 2.00		
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII	
								XIX		
				1.00	2.00	3.00	4.00	5.00	6.00 7.00 8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital			ST. JOSEPHS HOSPITAL-HIGHLAND IL	141336	41180	1	06/01/2004	N 0 0 3.00	
4.00	Subprovider - IPF								4.00	
5.00	Subprovider - IRF								5.00	
6.00	Subprovider - (Other)								6.00	
7.00	Swing Beds - SNF			ST. JOSEPHS HOSPITAL-SWING BED	14Z336	41180		08/19/2004	N 0 N 7.00	
8.00	Swing Beds - NF								8.00	
9.00	Hospital-Based SNF								9.00	
10.00	Hospital-Based NF								10.00	
11.00	Hospital-Based OLTC								11.00	
12.00	Hospital-Based HHA								12.00	
13.00	Separately Certified ASC								13.00	
14.00	Hospital-Based Hospice								14.00	
15.00	Hospital-Based Health Clinic - RHC								15.00	
16.00	Hospital-Based Health Clinic - FQHC								16.00	
17.00	Hospital-Based (CMHC) I								17.00	
18.00	Renal Dialysis								18.00	
19.00	Other								19.00	
								From:	To:	
								1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2018	06/30/2019 20.00	
21.00	Type of Control (see instructions)							1	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 24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/20/2019 4:12 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N				60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/20/2019 4:12 pm	
		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	37,204	0	255,460	
		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.	Y		5.06	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)	Y		148005	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/20/2019 4:12 pm		
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: HOSPITAL SISTERS HEALTH SYSTEM		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131				141.00	
142.00	Street: 4936 LAVERNA ROAD		PO Box:						142.00	
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62794		143.00			
									1.00	
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
									1.00	
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.								N	146.00
									1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
									1.00	
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
									1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/01/2018	09/30/2018		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: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/20/2019 4:12 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/08/2019	Y	10/08/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	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			Y	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			Y	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.			Y	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.			Y	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.			Y	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/20/2019 4:12 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	77,841.85	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	77,841.85	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	77,841.85	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,820	26	3,239			1.00
2.00	HMO and other (see instructions)	509	147				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,782	0	2,506			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	140			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,602	26	5,885			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,602	26	5,885	0.00	250.89	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)			49			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	250.89	27.00
28.00	Observation Bed Days		5	303			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			38			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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	543	8	985	1.00
2.00 HMO and other (see instructions)			155	42		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	543	8	985	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: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/20/2019 4:12 pm
				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)			0.308332 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,019,894		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		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	2,342,920		5.00
6.00	Medicaid charges	9,147,457		6.00
7.00	Medicaid cost (line 1 times line 6)	2,820,454		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	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		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)	650,226	1,124,422	1,774,648 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	200,485	1,124,422	1,324,907 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)	200,485	1,124,422	1,324,907 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)	919,067		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	149,275		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	229,654		27.01
28.00	Non-Medicare bad debt expense (see instructions)	689,413		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	292,947		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,617,854		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,617,854		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		2,027,040	2,027,040	2,058,434	4,085,474 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,058,598	1,058,598 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	156,279	5,461,245	5,617,524	-300	5,617,224 4.00
5.01	01160	COMMUNICATIONS	0	0	0	3,281	3,281 5.01
5.02	00550	DATA PROCESSING	166,065	1,422,617	1,588,682	0	1,588,682 5.02
5.03	00560	PURCHASING RECEIVING AND STORES	127,839	109,036	236,875	-57,056	179,819 5.03
5.04	00570	ADMITTING	400,842	11,354	412,196	0	412,196 5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	197,821	504,299	702,120	-1,150	700,970 5.05
5.06	00590	OTHER ADMIN & GENERAL	1,518,983	4,981,240	6,500,223	-896,355	5,603,868 5.06
6.00	00600	MAINTENANCE & REPAIRS	0	-47	-47	47	0 6.00
7.00	00700	OPERATION OF PLANT	285,810	600,693	886,503	-1,871	884,632 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	146	112,420	112,566	0	112,566 8.00
9.00	00900	HOUSEKEEPING	256,147	120,381	376,528	0	376,528 9.00
10.00	01000	DIETARY	320,763	416,762	737,525	0	737,525 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	414,055	49,904	463,959	0	463,959 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	186,636	272,234	458,870	-3,447	455,423 16.00
17.00	01700	SOCIAL SERVICE	178,508	62,989	241,497	0	241,497 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,124,349	1,296,759	3,421,108	-176,446	3,244,662 30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,115,530	2,376,474	3,492,004	-2,212,372	1,279,632 50.00
53.00	05300	ANESTHESIOLOGY	0	888,215	888,215	-19,705	868,510 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	858,881	657,021	1,515,902	-146,299	1,369,603 54.00
60.00	06000	LABORATORY	666,342	862,147	1,528,489	-510,604	1,017,885 60.00
65.00	06500	RESPIRATORY THERAPY	337,739	87,209	424,948	-52,671	372,277 65.00
66.00	06600	PHYSICAL THERAPY	747,530	21,010	768,540	-28,272	740,268 66.00
67.00	06700	OCCUPATIONAL THERAPY	175,610	2,015	177,625	15,402	193,027 67.00
68.00	06800	SPEECH PATHOLOGY	34,052	11,899	45,951	2,322	48,273 68.00
68.01	03040	AUDIOLOGY	57,402	87,557	144,959	-81,199	63,760 68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	109,368	15,524	124,892	2,996,350	3,121,242 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	667,673	667,673 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	562,006	825,972	1,387,978	-4,030	1,383,948 73.00
76.97	07697	CARDIAC REHABILITATION	209,434	11,368	220,802	-3,514	217,288 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	214,760	1,105,211	1,319,971	-635,214	684,757 76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	95,759	2,541	98,300	-2,455	95,845 90.00
91.00	09100	EMERGENCY	1,001,228	1,637,907	2,639,135	-111,932	2,527,203 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	429,442	429,442	-284	429,158 93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		1,856,331	1,856,331	-1,856,331	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,519,884	28,326,769	40,846,653	600	40,847,253 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	48,696	48,696	0	48,696 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	-198	4,012,835	4,012,637	-3	4,012,634 192.00
194.00	07950	TRANSPORTATION	26,683	12,252	38,935	-597	38,338 194.00
194.01	07951	FUND DEVELOPMENT	2,918	-40	2,878	0	2,878 194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	12,549,287	32,400,512	44,949,799	0	44,949,799 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet A
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	493,958	4,579,432	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-581,524	477,074	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,090,271	3,526,953	4.00
5.01	01160	COMMUNICATIONS	0	3,281	5.01
5.02	00550	DATA PROCESSING	1,777,364	3,366,046	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-28,680	151,139	5.03
5.04	00570	ADMITTING	0	412,196	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	700,970	5.05
5.06	00590	OTHER ADMIN & GENERAL	-2,278,637	3,325,231	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-31,766	852,866	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,155	111,411	8.00
9.00	00900	HOUSEKEEPING	-37,209	339,319	9.00
10.00	01000	DIETARY	0	737,525	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-250	463,709	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,533	450,890	16.00
17.00	01700	SOCIAL SERVICE	0	241,497	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,068,801	2,175,861	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-12,284	1,267,348	50.00
53.00	05300	ANESTHESIOLOGY	-847,795	20,715	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,220	1,364,383	54.00
60.00	06000	LABORATORY	-69,959	947,926	60.00
65.00	06500	RESPIRATORY THERAPY	-24,901	347,376	65.00
66.00	06600	PHYSICAL THERAPY	-242	740,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	193,027	67.00
68.00	06800	SPEECH PATHOLOGY	-478	47,795	68.00
68.01	03040	AUDIOLOGY	-444	63,316	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	3,121,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	667,673	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,383,948	73.00
76.97	07697	CARDIAC REHABILITATION	0	217,288	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	684,757	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	95,845	90.00
91.00	09100	EMERGENCY	-914,502	1,612,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	429,158	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,727,329	35,119,924	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	48,696	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	4,012,634	192.00
194.00	07950	TRANSPORTATION	0	38,338	194.00
194.01	07951	FUND DEVELOPMENT	0	2,878	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,727,329	39,222,470	200.00

RECLASSIFICATIONS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
11/20/2019 4:12 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	877,113		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	351,362		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
0			0	1,228,475		
	B - TELEPHONE					
1.00	COMMUNICATIONS	5.01	0	3,281		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
0			0	3,281		
	C - POSTAGE					
1.00	OTHER ADMIN & GENERAL	5.06	0	10,628		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
0			0	10,628		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,856,331		1.00
0			0	1,856,331		
	E - MED SUPPLIES - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	2,996,350		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	667,673		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
0			0	3,664,023		
	F - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	71,862		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
0			0	71,862		
	G - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,107		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,119		2.00
0			0	32,226		
	I - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	699,117		1.00
0			0	699,117		
	J - RECLASS NEGATIVE COST CENTER					
1.00	MAINTENANCE & REPAIRS	6.00	0	47		1.00
2.00	PHYSICIANS PRIVATE OFFICES	192.00	198	0		2.00
	TOTALS		198	47		
	K - REHAB ADMIN					
1.00	OCCUPATIONAL THERAPY	67.00	16,590	680		1.00
2.00	SPEECH PATHOLOGY	68.00	2,231	91		2.00
	TOTALS		18,821	771		
500.00	Grand Total: Increases		19,019	7,566,761		500.00

RECLASSIFICATIONS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
11/20/2019 4:12 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	300	10		1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	46,444	10		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	1,150	0		3.00
4.00	OTHER ADMIN & GENERAL	5.06	0	872,899	0		4.00
5.00	OPERATION OF PLANT	7.00		998	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,440	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	22,856	0		7.00
8.00	OPERATING ROOM	50.00	0	200,632	0		8.00
9.00	LABORATORY	60.00	0	1,611	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	2,118	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	394	0		11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	75,633	0		12.00
13.00	DRUGS CHARGED TO PATIENTS				0		13.00
	0		0	1,228,475			
	B - TELEPHONE						
1.00	OTHER ADMIN & GENERAL	5.06	0	1,858	0		1.00
2.00	OPERATION OF PLANT	7.00	0	826	0		2.00
3.00	TRANSPORTATION	194.00	0	597	0		3.00
	0		0	3,281			
	C - POSTAGE						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	10,612	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	7	0		2.00
3.00	AUDIOLOGY	68.01	0	9	0		3.00
	0		0	10,628			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,856,331	11		1.00
	0		0	1,856,331			
	E - MED SUPPLIES - IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	152,012	0		1.00
2.00	OPERATING ROOM	50.00	0	1,996,067	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	19,705	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,135	0		4.00
5.00	LABORATORY	60.00	0	508,965	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	50,553	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	8,286	0		7.00
8.00	OCCUPATIONAL THERAPY	67.00	0	1,868	0		8.00
9.00	AUDIOLOGY	68.01	0	81,190	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	259	0		10.00
11.00	CARDIAC REHABILITATION	76.97	0	3,514	0		11.00
12.00	HYPERBARIC OXYGEN THERAPY	76.98	0	632,265	0		12.00
13.00	CLINIC	90.00	0	2,455	0		13.00
14.00	EMERGENCY	91.00	0	110,462	0		14.00
15.00	O/P GERIATRIC PSYCH CENTER	93.00	0	284	0		15.00
16.00	PHYSICIANS PRIVATE OFFICES	192.00	0	3	0		16.00
	0		0	3,664,023			
	F - DRUGS CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	1,578	0		1.00
2.00	OPERATING ROOM	50.00	0	15,673	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,164	0		3.00
4.00	LABORATORY	60.00	0	28	0		4.00
5.00	HYPERBARIC OXYGEN THERAPY	76.98	0	2,949	0		5.00
6.00	EMERGENCY	91.00	0	1,470	0		6.00
	0		0	71,862			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	32,226	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	32,226			
	I - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	699,117	9		1.00
	0		0	699,117			
	J - RECLASS NEGATIVE COST CENTER						
1.00	OPERATION OF PLANT	7.00	0	47	0		1.00
2.00	PHYSICIANS PRIVATE OFFICES	192.00	0	198	0		2.00
	TOTALS		0	245			
	K - REHAB ADMIN						
1.00	PHYSICAL THERAPY	66.00	18,821	771	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		18,821	771			
500.00	Grand Total: Decreases		18,821	7,566,959			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,130,878	0	0	0	78,004	1.00	
2.00	Land Improvements	1,469,318	0	0	0	0	2.00	
3.00	Buildings and Fixtures	39,656,973	23,555	0	23,555	0	3.00	
4.00	Building Improvements	21,000	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	3,609,799	148,154	0	148,154	0	6.00	
7.00	HIT designated Assets	10,000,000	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	56,887,968	171,709	0	171,709	78,004	8.00	
9.00	Reconciling Items	32,472	23,555	0	23,555	0	9.00	
10.00	Total (line 8 minus line 9)	56,855,496	148,154	0	148,154	78,004	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,052,874	0				1.00	
2.00	Land Improvements	1,469,318	0				2.00	
3.00	Buildings and Fixtures	39,680,528	0				3.00	
4.00	Building Improvements	21,000	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	3,757,953	0				6.00	
7.00	HIT designated Assets	10,000,000	0				7.00	
8.00	Subtotal (sum of lines 1-7)	56,981,673	0				8.00	
9.00	Reconciling Items	56,027	0				9.00	
10.00	Total (line 8 minus line 9)	56,925,646	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,027,040	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,027,040	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,027,040				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,027,040				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,223,720	0	43,223,720	0.758555	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,757,953	0	13,757,953	0.241445	0	2.00
3.00	Total (sum of lines 1-2)	56,981,673	0	56,981,673	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,821,881	877,113	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	117,593	351,362	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,939,474	1,228,475	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	1,856,331	24,107	0	0	4,579,432	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,119	0	0	477,074	2.00
3.00	Total (sum of lines 1-2)	1,856,331	32,226	0	0	5,056,506	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,051,318			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	1,022,870			0	12.00
13.00	Laundry and linen service	B	-1,155	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,533	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	-478	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-953,802	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	5	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/20/2019 4:12 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 MISCELLANEOUS INCOME	B	-28,680	PURCHASING RECEIVING AND STORES	5.03	0	33.01
33.02 MISCELLANEOUS INCOME	B	-4,504	OTHER ADMIN & GENERAL	5.06	0	33.02
33.03 MISCELLANEOUS INCOME	B	-37,209	HOUSEKEEPING	9.00	0	33.03
33.04 MISCELLANEOUS INCOME	B	-250	NURSING ADMINISTRATION	13.00	0	33.04
33.05 MISCELLANEOUS INCOME	B	-45	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06 MISCELLANEOUS INCOME	B	-38,845	LABORATORY	60.00	0	33.06
33.07 MISCELLANEOUS INCOME	B	-242	PHYSICAL THERAPY	66.00	0	33.07
33.08 MISCELLANEOUS INCOME	B	-444	AUDIOLOGY	68.01	0	33.08
33.09 ADVERTISING EXPENSES	A	-576	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10 MEDICAID TAX ASSESSMENT	A	-1,108,178	OTHER ADMIN & GENERAL	5.06	0	33.10
33.11 CRNA-CONTRACT LABOR	A	-847,795	ANESTHESIOLOGY	53.00	0	33.11
33.12 PENSION ADJUSTMENT	A	-888,704	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 USEFUL LIVES CARRYFORWARD ADJUSTMEN	A	111,756	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14 LOBBYING EXPENSE	A	-14,362	OTHER ADMIN & GENERAL	5.06	0	33.14
33.15 COMMUNITY RELATIONS BENEFITS	A	-19,283	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16 COMMUNITY RELATIONS SALARY	A	-71,846	OTHER ADMIN & GENERAL	5.06	0	33.16
33.17 COMMUNITY RELATIONS OTHER EXPENSE	A	-31,706	OTHER ADMIN & GENERAL	5.06	0	33.17
33.18 SELF-INSURANCE ADJUSTMENT	A	-1,203,716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19 PROPERTY TAX NOT RELATED TO PATIENT	A	-2,618	OPERATION OF PLANT	7.00	0	33.19
33.20 MISCELLANEOUS INCOME	B	-29,148	OPERATION OF PLANT	7.00	0	33.20
33.21 ADVERTISING EXPENSES	A	-5,175	RADIOLOGY-DIAGNOSTIC	54.00	0	33.21
33.22 BUILDING RELIFING	A	493,958	CAP REL COSTS-BLDG & FIXT	1.00	9	33.22
33.23 EQUIPMENT RELIFING	A	260,522	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.23
33.24 MARKETING BENEFITS	A	-20,987	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25 MARKETING SALARIES	A	-78,192	OTHER ADMIN & GENERAL	5.06	0	33.25
33.26 MARKETING OTHER EXPENSE	A	-150,832	OTHER ADMIN & GENERAL	5.06	0	33.26
33.27 MISCELLANEOUS INCOME	B	-284	OPERATING ROOM	50.00	0	33.27
33.28 ALCOHOL	B	-1,299	OTHER ADMIN & GENERAL	5.06	0	33.28
33.29 ATHLETICARE BENEFITS	A	-4,219	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29
33.30 ATHLETICARE SALARIES	A	-15,719	OTHER ADMIN & GENERAL	5.06	0	33.30
33.31 ATHLETICARE OTHER EXPENSE	A	-296	OTHER ADMIN & GENERAL	5.06	0	33.31
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,727,329				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/20/2019 4:12 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	2,816,321	2,769,112 1.00
2.00		5.02	DATA PROCESSING	CONTRACTED SERVICES - ISC	3,192,689	1,415,325 2.00
3.00		5.06	OTHER ADMIN & GENERAL	CONTRACTED SERVICES - SSC	897,212	1,644,392 3.00
4.00		5.06	OTHER ADMIN & GENERAL	PURCHASED SERVICES	0	54,523 4.00
4.01		0.00			0	0 4.01
4.02		0.00			0	0 4.02
4.03		0.00			0	0 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,906,222	5,883,352	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
				Name	Percentage of Ownership	

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

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

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

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

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

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

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

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/20/2019 4:12 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	47,209	0		1.00
2.00	1,777,364	0		2.00
3.00	-747,180	0		3.00
4.00	-54,523	0		4.00
4.01	0	0		4.01
4.02	0	10		4.02
4.03	0	0		4.03
5.00	1,022,870			5.00

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

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

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

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

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

6.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
11/20/2019 4:12 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,068,801	1,068,801	0	0	0	1.00
2.00	50.00	OPERATING ROOM	12,000	12,000	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,050	0	1,050	0	0	3.00
4.00	60.00	LABORATORY	92,108	31,114	60,994	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	30,401	24,901	5,500	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	5,125	0	5,125	0	0	6.00
7.00	76.98	HYPERBARIC OXYGEN THERAPY	25,000	0	25,000	0	0	7.00
8.00	91.00	EMERGENCY	1,046,720	589,594	457,126	0	0	8.00
9.00	91.00	EMERGENCY	218,883	218,883	0	0	0	9.00
10.00	91.00	EMERGENCY	106,025	106,025	0	0	0	10.00
11.00	91.00	EMERGENCY	96,000	0	96,000	0	0	11.00
200.00			2,702,113	2,051,318	650,795		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,068,801		1.00
2.00	50.00	OPERATING ROOM	0	0	0	12,000		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	60.00	LABORATORY	0	0	0	31,114		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	24,901		5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0		6.00
7.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	589,594		8.00
9.00	91.00	EMERGENCY	0	0	0	218,883		9.00
10.00	91.00	EMERGENCY	0	0	0	106,025		10.00
11.00	91.00	EMERGENCY	0	0	0	0		11.00
200.00			0	0	0	2,051,318		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2019 4:12 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	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	123.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.14	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)	38.07	38.07	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)					9,403	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)					9,403	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)					9,403	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)					76.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					11,421	22.00
23.00	Total salary equivalency (see instructions)					11,421	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2019 4:12 pm	
				Speech Pathology		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		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)	76.14	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)					11,421	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					11,421	63.00
64.00	Total cost of outside supplier services (from your records)					11,899	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					478	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	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					0	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					0	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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			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	4,579,432	4,579,432			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	477,074		477,074		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,526,953	29,288	510	3,556,751	4.00
5.01	01160	COMMUNICATIONS	3,281	4,197	7,394	0	14,872 5.01
5.02	00550	DATA PROCESSING	3,366,046	74,705	60,752	47,659	1,619 5.02
5.03	00560	PURCHASING RECEIVING AND STORES	151,139	135,308	755	36,689	183 5.03
5.04	00570	ADMITTING	412,196	43,059	396	115,038	489 5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	700,970	64,140	671	56,773	183 5.05
5.06	00590	OTHER ADMIN & GENERAL	3,325,231	364,421	6,046	435,936	1,527 5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	852,866	240,102	2,756	82,025	275 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	111,411	4,716	0	42	0 8.00
9.00	00900	HOUSEKEEPING	339,319	96,871	1,190	73,512	244 9.00
10.00	01000	DIETARY	737,525	124,225	1,387	92,056	244 10.00
11.00	01100	CAFETERIA	0	114,415	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	463,709	34,994	4,236	118,830	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	450,890	56,972	239	53,563	519 16.00
17.00	01700	SOCIAL SERVICE	241,497	14,526	0	51,230	31 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,175,861	830,335	34,122	609,674	1,863 30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,267,348	539,958	135,442	320,148	1,038 50.00
53.00	05300	ANESTHESIOLOGY	20,715	0	6,042	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,364,383	385,314	129,144	246,492	580 54.00
60.00	06000	LABORATORY	947,926	148,230	21,142	191,235	580 60.00
65.00	06500	RESPIRATORY THERAPY	347,376	98,144	7,323	96,928	336 65.00
66.00	06600	PHYSICAL THERAPY	740,026	217,275	4,124	209,134	702 66.00
67.00	06700	OCCUPATIONAL THERAPY	193,027	45,889	298	55,160	0 67.00
68.00	06800	SPEECH PATHOLOGY	47,795	0	301	10,413	0 68.00
68.01	03040	AUDIOLOGY	63,316	26,599	1,068	16,474	0 68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,121,242	79,845	6,317	31,388	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	667,673	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,383,948	55,604	3,409	161,291	275 73.00
76.97	07697	CARDIAC REHABILITATION	217,288	71,120	4,849	60,106	153 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	684,757	162,803	1,856	61,634	305 76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	95,845	0	0	27,482	0 90.00
91.00	09100	EMERGENCY	1,612,701	340,368	24,702	287,344	763 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	429,158	116,867	663	0	244 93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,119,924	4,520,290	467,134	3,548,256	12,153 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	48,696	36,834	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,012,634	0	4,151	0	2,719 192.00
194.00	07950	TRANSPORTATION	38,338	0	5,789	7,658	0 194.00
194.01	07951	FUND DEVELOPMENT	2,878	22,308	0	837	0 194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	39,222,470	4,579,432	477,074	3,556,751	14,872 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	3,550,781					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	141,130	465,204				5.03
5.04	00570	ADMITTING	210,714	1,074	782,966			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	15,681	3	0	838,421		5.05
5.06	00590	OTHER ADMIN & GENERAL	1,781,761	2,999	0	0	5,917,921	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,841	4,044	0	0	1,189,909	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	116,169	8.00
9.00	00900	HOUSEKEEPING	20,581	1,332	0	0	533,049	9.00
10.00	01000	DIETARY	34,302	118	0	0	989,857	10.00
11.00	01100	CAFETERIA	0	0	0	0	114,415	11.00
13.00	01300	NURSING ADMINISTRATION	0	19	0	0	621,788	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	151,910	117	0	0	714,210	16.00
17.00	01700	SOCIAL SERVICE	11,761	3	0	0	319,048	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,894	2,366	147,399	40,921	4,044,435	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	116,628	3,011	41,087	75,604	2,500,264	50.00
53.00	05300	ANESTHESIOLOGY	0	79	19,407	22,354	68,597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,867	1,630	139,422	260,612	2,632,444	54.00
60.00	06000	LABORATORY	88,206	5,995	133,892	143,264	1,680,470	60.00
65.00	06500	RESPIRATORY THERAPY	23,522	254	34,493	16,907	625,283	65.00
66.00	06600	PHYSICAL THERAPY	71,545	328	26,717	30,131	1,299,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,661	0	10,666	5,905	327,606	67.00
68.00	06800	SPEECH PATHOLOGY	6,860	0	852	794	67,015	68.00
68.01	03040	AUDIOLOGY	18,621	5	0	2,549	128,632	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	67,625	354,692	48,673	27,344	3,737,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	79,036	29,286	24,283	800,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,229	420	103,028	70,237	1,914,441	73.00
76.97	07697	CARDIAC REHABILITATION	43,123	77	0	5,028	401,744	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	91,146	690	409	31,268	1,034,868	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	28	3,910	127,265	90.00
91.00	09100	EMERGENCY	172,492	1,177	47,607	73,421	2,560,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	15,681	318	0	3,889	566,820	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,550,781	459,787	782,966	838,421	35,034,211	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	5,368	0	0	90,898	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	33	0	0	4,019,537	192.00
194.00	07950	TRANSPORTATION	0	16	0	0	51,801	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	26,023	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,550,781	465,204	782,966	838,421	39,222,470	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	5,917,921					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	211,436	0	1,401,345			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,642	0	1,824	138,635		8.00
9.00	00900	HOUSEKEEPING	94,718	0	37,456	0	665,223	9.00
10.00	01000	DIETARY	175,889	0	48,033	430	9,175	10.00
11.00	01100	CAFETERIA	20,331	0	44,240	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,486	0	13,531	0	176	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,909	0	22,029	0	7,146	16.00
17.00	01700	SOCIAL SERVICE	56,692	0	5,617	0	1,059	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	718,660	0	321,058	57,981	240,240	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	444,274	0	208,781	21,189	49,318	50.00
53.00	05300	ANESTHESIOLOGY	12,189	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	467,762	0	148,986	13,621	35,070	54.00
60.00	06000	LABORATORY	298,604	0	57,315	0	23,909	60.00
65.00	06500	RESPIRATORY THERAPY	111,107	0	37,949	727	15,925	65.00
66.00	06600	PHYSICAL THERAPY	230,995	0	84,012	10,811	25,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,213	0	17,743	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,908	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	22,857	0	10,285	0	397	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	664,054	0	30,873	0	5,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,202	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,179	0	21,500	0	3,794	73.00
76.97	07697	CARDIAC REHABILITATION	71,386	0	27,500	0	7,940	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	183,887	0	62,950	4,039	20,336	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	22,614	0	0	0	7,279	90.00
91.00	09100	EMERGENCY	454,991	0	131,607	28,569	75,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	100,719	0	45,188	79	9,970	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,173,704	0	1,378,477	137,446	538,751	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	16,152	0	14,242	0	3,441	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	714,236	0	0	1,189	123,031	192.00
194.00	07950	TRANSPORTATION	9,205	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	4,624	0	8,626	0	0	194.01
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)	5,917,921	0	1,401,345	138,635	665,223	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,223,384					10.00
11.00	01100	CAFETERIA	351,676	530,662				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,871	758,852			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,506	0	881,800		16.00
17.00	01700	SOCIAL SERVICE	0	7,554	25,411	0	415,381	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	854,572	108,608	336,536	479,106	349,807	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,491	45,006	139,632	97,048	43,716	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,842	2,433	11,155	0	54.00
60.00	06000	LABORATORY	0	36,435	117	37,927	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,467	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,815	9,632	95,375	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,537	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,278	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	2,034	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	8,687	9	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	13,859	44,459	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	8,426	27,562	13,386	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	10,344	33,878	7,808	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,939	16,948	0	0	90.00
91.00	09100	EMERGENCY	73	41,549	122,235	81,431	21,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	13,572	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,223,384	407,757	758,852	823,236	415,381	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	119,622	0	58,564	0	192.00
194.00	07950	TRANSPORTATION	0	3,167	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	116	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,223,384	530,662	758,852	881,800	415,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,511,003	0	7,511,003	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,552,719	0	3,552,719	50.00
53.00	05300	ANESTHESIOLOGY	0	80,786	0	80,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,348,313	0	3,348,313	54.00
60.00	06000	LABORATORY	0	2,134,777	0	2,134,777	60.00
65.00	06500	RESPIRATORY THERAPY	0	810,458	0	810,458	65.00
66.00	06600	PHYSICAL THERAPY	0	1,788,207	0	1,788,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	410,099	0	410,099	67.00
68.00	06800	SPEECH PATHOLOGY	0	80,201	0	80,201	68.00
68.01	03040	AUDIOLOGY	0	164,205	0	164,205	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	4,446,616	0	4,446,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	942,480	0	942,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,338,232	0	2,338,232	73.00
76.97	07697	CARDIAC REHABILITATION	0	557,944	0	557,944	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,358,110	0	1,358,110	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	179,045	0	179,045	90.00
91.00	09100	EMERGENCY	0	3,518,453	0	3,518,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	736,348	0	736,348	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,957,996	0	33,957,996	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	124,733	0	124,733	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,036,179	0	5,036,179	192.00
194.00	07950	TRANSPORTATION	0	64,173	0	64,173	194.00
194.01	07951	FUND DEVELOPMENT	0	39,389	0	39,389	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	39,222,470	0	39,222,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	29,288	510	29,798	4.00
5.01	01160	COMMUNICATIONS	0	4,197	7,394	11,591	5.01
5.02	00550	DATA PROCESSING	1,343,945	74,705	60,752	1,479,402	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	135,308	755	136,063	5.03
5.04	00570	ADMITTING	0	43,059	396	43,455	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	64,140	671	64,811	5.05
5.06	00590	OTHER ADMIN & GENERAL	28,965	364,421	6,046	399,432	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	240,102	2,756	242,858	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,716	0	4,716	8.00
9.00	00900	HOUSEKEEPING	0	96,871	1,190	98,061	9.00
10.00	01000	DIETARY	0	124,225	1,387	125,612	10.00
11.00	01100	CAFETERIA	0	114,415	0	114,415	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,994	4,236	39,230	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,972	239	57,211	16.00
17.00	01700	SOCIAL SERVICE	0	14,526	0	14,526	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	830,335	34,122	864,457	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	539,958	135,442	675,400	50.00
53.00	05300	ANESTHESIOLOGY	0	0	6,042	6,042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	385,314	129,144	514,458	54.00
60.00	06000	LABORATORY	0	148,230	21,142	169,372	60.00
65.00	06500	RESPIRATORY THERAPY	0	98,144	7,323	105,467	65.00
66.00	06600	PHYSICAL THERAPY	0	217,275	4,124	221,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	45,889	298	46,187	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	301	301	68.00
68.01	03040	AUDIOLOGY	0	26,599	1,068	27,667	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	79,845	6,317	86,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,604	3,409	59,013	73.00
76.97	07697	CARDIAC REHABILITATION	0	71,120	4,849	75,969	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	162,803	1,856	164,659	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	230	90.00
91.00	09100	EMERGENCY	0	340,368	24,702	365,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	116,867	663	117,530	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,372,910	4,520,290	467,134	6,360,334	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	36,834	0	36,834	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	4,151	4,151	192.00
194.00	07950	TRANSPORTATION	0	0	5,789	5,789	194.00
194.01	07951	FUND DEVELOPMENT	0	22,308	0	22,308	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,372,910	4,579,432	477,074	6,429,416	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			COMMUNICATIONS	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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	01160	COMMUNICATIONS	11,591					5.01
5.02	00550	DATA PROCESSING	1,261	1,481,062				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	143	58,866	195,379			5.03
5.04	00570	ADMITTING	381	87,891	451	133,142		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	143	6,541	1	0	71,972	5.05
5.06	00590	OTHER ADMIN & GENERAL	1,190	743,186	1,260	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	214	3,270	1,699	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	190	8,585	559	0	0	9.00
10.00	01000	DIETARY	190	14,308	50	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	405	63,363	49	0	0	16.00
17.00	01700	SOCIAL SERVICE	24	4,906	1	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,452	84,212	994	25,070	3,510	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	809	48,647	1,264	6,986	6,485	50.00
53.00	05300	ANESTHESIOLOGY	0	0	33	3,300	1,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	452	43,741	684	23,707	22,412	54.00
60.00	06000	LABORATORY	452	36,791	2,518	22,767	12,288	60.00
65.00	06500	RESPIRATORY THERAPY	262	9,811	107	5,865	1,450	65.00
66.00	06600	PHYSICAL THERAPY	547	29,842	138	4,543	2,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,950	0	1,814	506	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,862	0	145	68	68.00
68.01	03040	AUDIOLOGY	0	7,767	2	0	219	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	28,207	148,966	8,276	2,345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	33,194	4,980	2,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	214	56,822	176	17,519	6,025	73.00
76.97	07697	CARDIAC REHABILITATION	119	17,987	33	0	431	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	238	38,018	290	70	2,682	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5	335	90.00
91.00	09100	EMERGENCY	595	71,948	494	8,095	6,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	190	6,541	133	0	334	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,471	1,481,062	193,104	133,142	71,972	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	2,254	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,120	0	14	0	0	192.00
194.00	07950	TRANSPORTATION	0	0	7	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
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)	11,591	1,481,062	195,379	133,142	71,972	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	1,148,720					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	41,041	0	289,769			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,007	0	377	9,100		8.00
9.00	00900	HOUSEKEEPING	18,385	0	7,745	0	134,141	9.00
10.00	01000	DIETARY	34,141	0	9,932	28	1,850	10.00
11.00	01100	CAFETERIA	3,946	0	9,148	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	21,446	0	2,798	0	36	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,634	0	4,555	0	1,441	16.00
17.00	01700	SOCIAL SERVICE	11,004	0	1,161	0	213	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	139,509	0	66,387	3,806	48,444	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	86,237	0	43,172	1,391	9,945	50.00
53.00	05300	ANESTHESIOLOGY	2,366	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,796	0	30,807	894	7,072	54.00
60.00	06000	LABORATORY	57,961	0	11,852	0	4,821	60.00
65.00	06500	RESPIRATORY THERAPY	21,567	0	7,847	48	3,211	65.00
66.00	06600	PHYSICAL THERAPY	44,838	0	17,372	710	5,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,299	0	3,669	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,311	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	4,437	0	2,127	0	80	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	128,897	0	6,384	0	1,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,602	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,031	0	4,446	0	765	73.00
76.97	07697	CARDIAC REHABILITATION	13,857	0	5,686	0	1,601	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	35,694	0	13,017	265	4,101	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,389	0	0	0	1,468	90.00
91.00	09100	EMERGENCY	88,317	0	27,214	1,875	15,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	19,550	0	9,344	5	2,010	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,004,262	0	285,040	9,022	108,638	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	3,135	0	2,945	0	694	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	138,638	0	0	78	24,809	192.00
194.00	07950	TRANSPORTATION	1,787	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	898	0	1,784	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,148,720	0	289,769	9,100	134,141	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	186,882					10.00
11.00	01100	CAFETERIA	53,721	181,230				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,396	68,909			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,929	0	156,036		16.00
17.00	01700	SOCIAL SERVICE	0	2,580	2,307	0	37,151	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	130,544	37,091	30,559	84,778	31,286	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	533	15,370	12,680	17,173	3,910	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,582	221	1,974	0	54.00
60.00	06000	LABORATORY	0	12,443	11	6,711	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,648	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,865	875	16,877	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,233	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	437	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	695	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,967	1	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	4,733	4,037	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	2,878	2,503	2,369	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,533	3,076	1,382	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,687	1,539	0	0	90.00
91.00	09100	EMERGENCY	11	14,190	11,100	14,409	1,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	2,073	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	186,882	139,257	68,909	145,673	37,151	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	40,851	0	10,363	0	192.00
194.00	07950	TRANSPORTATION	0	1,082	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	40	0	0	0	194.01
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)	186,882	181,230	68,909	156,036	37,151	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,557,211	0	1,557,211	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		932,684	0	932,684	50.00
53.00	05300	ANESTHESIOLOGY		13,658	0	13,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		751,865	0	751,865	54.00
60.00	06000	LABORATORY		339,589	0	339,589	60.00
65.00	06500	RESPIRATORY THERAPY		163,095	0	163,095	65.00
66.00	06600	PHYSICAL THERAPY		357,501	0	357,501	66.00
67.00	06700	OCCUPATIONAL THERAPY		73,120	0	73,120	67.00
68.00	06800	SPEECH PATHOLOGY		6,211	0	6,211	68.00
68.01	03040	AUDIOLOGY		43,132	0	43,132	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		413,651	0	413,651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		67,859	0	67,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		221,132	0	221,132	73.00
76.97	07697	CARDIAC REHABILITATION		123,936	0	123,936	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		267,541	0	267,541	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		9,653	0	9,653	90.00
91.00	09100	EMERGENCY		629,216	0	629,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER		157,710	0	157,710	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,128,764	0	6,128,764	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN		45,862	0	45,862	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		221,024	0	221,024	192.00
194.00	07950	TRANSPORTATION		8,729	0	8,729	194.00
194.01	07951	FUND DEVELOPMENT		25,037	0	25,037	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,429,416	0	6,429,416	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (TIME SPENT)	
			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	97,100					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		959,666				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	621	1,025	12,393,206			4.00
5.01	01160	COMMUNICATIONS	89	14,873	0	487		5.01
5.02	00550	DATA PROCESSING	1,584	122,206	166,065	53	3,623	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,869	1,518	127,839	6	144	5.03
5.04	00570	ADMITTING	913	796	400,842	16	215	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,360	1,350	197,821	6	16	5.05
5.06	00590	OTHER ADMIN & GENERAL	7,727	12,162	1,518,983	50	1,818	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,091	5,544	285,810	9	8	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100	0	146	0	0	8.00
9.00	00900	HOUSEKEEPING	2,054	2,394	256,147	8	21	9.00
10.00	01000	DIETARY	2,634	2,790	320,763	8	35	10.00
11.00	01100	CAFETERIA	2,426	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	742	8,521	414,055	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,208	481	186,636	17	155	16.00
17.00	01700	SOCIAL SERVICE	308	0	178,508	1	12	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,606	68,639	2,124,349	61	206	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,449	272,452	1,115,530	34	119	50.00
53.00	05300	ANESTHESIOLOGY	0	12,154	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,170	259,781	858,881	19	107	54.00
60.00	06000	LABORATORY	3,143	42,529	666,342	19	90	60.00
65.00	06500	RESPIRATORY THERAPY	2,081	14,730	337,739	11	24	65.00
66.00	06600	PHYSICAL THERAPY	4,607	8,295	728,709	23	73	66.00
67.00	06700	OCCUPATIONAL THERAPY	973	600	192,200	0	17	67.00
68.00	06800	SPEECH PATHOLOGY	0	605	36,283	0	7	68.00
68.01	03040	AUDIOLOGY	564	2,148	57,402	0	19	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,693	12,707	109,368	0	69	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179	6,858	562,006	9	139	73.00
76.97	07697	CARDIAC REHABILITATION	1,508	9,755	209,434	5	44	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,452	3,734	214,760	10	93	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	95,759	0	0	90.00
91.00	09100	EMERGENCY	7,217	49,690	1,001,228	25	176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	2,478	1,334	0	8	16	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,846	939,671	12,363,605	398	3,623	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	781	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	8,350	0	89	0	192.00
194.00	07950	TRANSPORTATION	0	11,645	26,683	0	0	194.00
194.01	07951	FUND DEVELOPMENT	473	0	2,918	0	0	194.01
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)	4,579,432	477,074	3,556,751	14,872	3,550,781	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.162019	0.497125	0.286992	30.537988	980.066519	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			29,798	11,591	1,481,062	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002404	23.800821	408.794369	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: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			PURCHASING RECEIVING AND STORES (SUPPLY EXP ENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	3,929,899					5.03
5.04	00570	ADMITTING	9,072	26,717,754				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	29	0	110,134,461			5.05
5.06	00590	OTHER ADMIN & GENERAL	25,335	0	0	-5,917,921	33,304,549	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	34,166	0	0	0	1,189,909	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	116,169	8.00
9.00	00900	HOUSEKEEPING	11,251	0	0	0	533,049	9.00
10.00	01000	DIETARY	1,000	0	0	0	989,857	10.00
11.00	01100	CAFETERIA	0	0	0	0	114,415	11.00
13.00	01300	NURSING ADMINISTRATION	161	0	0	0	621,788	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	992	0	0	0	714,210	16.00
17.00	01700	SOCIAL SERVICE	29	0	0	0	319,048	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,991	5,029,765	5,375,123	0	4,044,435	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,434	1,402,056	9,930,913	0	2,500,264	50.00
53.00	05300	ANESTHESIOLOGY	665	662,255	2,936,276	0	68,597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,768	4,757,630	34,236,849	0	2,632,444	54.00
60.00	06000	LABORATORY	50,641	4,568,897	18,818,400	0	1,680,470	60.00
65.00	06500	RESPIRATORY THERAPY	2,145	1,177,033	2,220,794	0	625,283	65.00
66.00	06600	PHYSICAL THERAPY	2,773	911,689	3,957,847	0	1,299,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	363,955	775,631	0	327,606	67.00
68.00	06800	SPEECH PATHOLOGY	0	29,081	104,326	0	67,015	68.00
68.01	03040	AUDIOLOGY	40	0	334,834	0	128,632	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,996,310	1,660,903	3,591,747	0	3,737,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	667,673	999,347	3,189,716	0	800,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,548	3,515,714	9,225,910	0	1,914,441	73.00
76.97	07697	CARDIAC REHABILITATION	654	0	660,405	0	401,744	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,830	13,963	4,107,120	0	1,034,868	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	946	513,547	0	127,265	90.00
91.00	09100	EMERGENCY	9,946	1,624,520	9,644,178	0	2,560,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	2,684	0	510,845	0	566,820	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,884,137	26,717,754	110,134,461	-5,917,921	29,116,290	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	45,347	0	0	0	90,898	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	281	0	0	0	4,019,537	192.00
194.00	07950	TRANSPORTATION	134	0	0	0	51,801	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	26,023	194.01
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)	465,204	782,966	838,421		5,917,921	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.118376	0.029305	0.007613		0.177691	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	195,379	133,142	71,972		1,148,720	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.049716	0.004983	0.000653		0.034491	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: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description		MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	76,846			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100	165,470		8.00
9.00	00900	HOUSEKEEPING	0	2,054	0	15,080	9.00
10.00	01000	DIETARY	0	2,634	513	208	10.00
11.00	01100	CAFETERIA	0	2,426	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	742	0	4	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,208	0	162	16.00
17.00	01700	SOCIAL SERVICE	0	308	0	24	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	17,606	69,205	5,446	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,449	25,290	1,118	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,170	16,257	795	54.00
60.00	06000	LABORATORY	0	3,143	0	542	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,081	868	361	65.00
66.00	06600	PHYSICAL THERAPY	0	4,607	12,904	580	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	973	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	564	0	9	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,693	0	133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,179	0	86	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,508	0	180	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,452	4,821	461	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	165	90.00
91.00	09100	EMERGENCY	0	7,217	34,099	1,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	2,478	94	226	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	75,592	164,051	12,213	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	781	0	78	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,419	2,789	192.00
194.00	07950	TRANSPORTATION	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	473	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,401,345	138,635	665,223	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	18.235757	0.837826	44.112931	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	289,769	9,100	134,141	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.770775	0.054995	8.895292	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: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			CAFETERIA (MEALS FTES)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	18,264					11.00
13.00	01300	NURSING ADMINISTRATION	443	162,219				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	396	0	1,581			16.00
17.00	01700	SOCIAL SERVICE	260	5,432	0	5,416		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,738	71,941	859	4,561	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,549	29,849	174	570	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,268	520	20	0	0	54.00
60.00	06000	LABORATORY	1,254	25	68	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	670	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,095	2,059	171	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	225	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	70	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	299	2	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	477	9,504	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	290	5,892	24	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	356	7,242	14	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	170	3,623	0	0	0	90.00
91.00	09100	EMERGENCY	1,430	26,130	146	285	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,034	162,219	1,476	5,416	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,117	0	105	0	0	192.00
194.00	07950	TRANSPORTATION	109	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	4	0	0	0	0	194.01
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)	530,662	758,852	881,800	415,381	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.055081	4.677948	557.748261	76.695162	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	181,230	68,909	156,036	37,151	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.922799	0.424790	98.694497	6.859490	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,511,003		7,511,003	0	0	30.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,552,719		3,552,719	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	80,786		80,786	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,348,313		3,348,313	0	0	54.00	
60.00	06000	LABORATORY	2,134,777		2,134,777	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	810,458	0	810,458	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,788,207	0	1,788,207	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	410,099	0	410,099	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	80,201	0	80,201	0	0	68.00	
68.01	03040	AUDIOLOGY	164,205	0	164,205	0	0	68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,446,616		4,446,616	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	942,480		942,480	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,338,232		2,338,232	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	557,944		557,944	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,358,110		1,358,110	0	0	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	179,045		179,045	0	0	90.00	
91.00	09100	EMERGENCY	3,518,453		3,518,453	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	375,205		375,205	0	0	92.00	
93.00	04950	O/P GERIATRIC PSYCH CENTER	736,348		736,348	0	0	93.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	34,333,201	0	34,333,201	0	0	200.00	
201.00		Less Observation Beds	375,205		375,205			201.00	
202.00		Total (see instructions)	33,957,996	0	33,957,996	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet C Part I Date/Time Prepared: 11/20/2019 4:12 pm		
					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	4,952,068		4,952,068					30.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0					33.00	
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	1,402,056	8,528,857	9,930,913	0.357743	0.000000			50.00	
53.00	05300	ANESTHESIOLOGY	662,255	2,274,021	2,936,276	0.027513	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,757,630	29,479,219	34,236,849	0.097799	0.000000			54.00	
60.00	06000	LABORATORY	4,568,897	14,249,503	18,818,400	0.113441	0.000000			60.00	
65.00	06500	RESPIRATORY THERAPY	1,177,033	1,043,761	2,220,794	0.364941	0.000000			65.00	
66.00	06600	PHYSICAL THERAPY	911,689	3,046,158	3,957,847	0.451813	0.000000			66.00	
67.00	06700	OCCUPATIONAL THERAPY	363,955	411,676	775,631	0.528730	0.000000			67.00	
68.00	06800	SPEECH PATHOLOGY	29,081	75,245	104,326	0.768754	0.000000			68.00	
68.01	03040	AUDIOLOGY	0	334,834	334,834	0.490407	0.000000			68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,660,903	1,930,844	3,591,747	1.238009	0.000000			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	999,347	2,190,369	3,189,716	0.295475	0.000000			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,515,714	5,710,196	9,225,910	0.253442	0.000000			73.00	
76.97	07697	CARDIAC REHABILITATION	0	660,405	660,405	0.844851	0.000000			76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	13,963	4,093,157	4,107,120	0.330672	0.000000			76.98	
OUTPATIENT SERVICE COST CENTERS											
90.00	09000	CLINIC	946	512,601	513,547	0.348644	0.000000			90.00	
91.00	09100	EMERGENCY	1,624,520	8,019,658	9,644,178	0.364827	0.000000			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	77,697	345,358	423,055	0.886894	0.000000			92.00	
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	510,845	510,845	1.441431	0.000000			93.00	
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE								113.00	
200.00		Subtotal (see instructions)	26,717,754	83,416,707	110,134,461					200.00	
201.00		Less Observation Beds								201.00	
202.00		Total (see instructions)	26,717,754	83,416,707	110,134,461					202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
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
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
68.01	03040	AUDIOLOGY	0.000000			68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
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	0.000000			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000			93.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,511,003		7,511,003	0	7,511,003	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,552,719		3,552,719	0	3,552,719	50.00
53.00	05300	ANESTHESIOLOGY	80,786		80,786	0	80,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,348,313		3,348,313	0	3,348,313	54.00
60.00	06000	LABORATORY	2,134,777		2,134,777	0	2,134,777	60.00
65.00	06500	RESPIRATORY THERAPY	810,458	0	810,458	0	810,458	65.00
66.00	06600	PHYSICAL THERAPY	1,788,207	0	1,788,207	0	1,788,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	410,099	0	410,099	0	410,099	67.00
68.00	06800	SPEECH PATHOLOGY	80,201	0	80,201	0	80,201	68.00
68.01	03040	AUDIOLOGY	164,205	0	164,205	0	164,205	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,446,616		4,446,616	0	4,446,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	942,480		942,480	0	942,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,338,232		2,338,232	0	2,338,232	73.00
76.97	07697	CARDIAC REHABILITATION	557,944		557,944	0	557,944	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,358,110		1,358,110	0	1,358,110	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	179,045		179,045	0	179,045	90.00
91.00	09100	EMERGENCY	3,518,453		3,518,453	0	3,518,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	375,205		375,205		375,205	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	736,348		736,348	0	736,348	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,333,201	0	34,333,201	0	34,333,201	200.00
201.00		Less Observation Beds	375,205		375,205		375,205	201.00
202.00		Total (see instructions)	33,957,996	0	33,957,996	0	33,957,996	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet C Part I Date/Time Prepared: 11/20/2019 4:12 pm		
					Title XIX			Hospital		Cost	
Cost Center Description					Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
					Inpatient	Outpatient	Total (col. 6 + col. 7)				
					6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		4,952,068		4,952,068					30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		0					33.00
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM		1,402,056	8,528,857	9,930,913	0.357743	0.000000			50.00
53.00	05300	ANESTHESIOLOGY		662,255	2,274,021	2,936,276	0.027513	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,757,630	29,479,219	34,236,849	0.097799	0.000000			54.00
60.00	06000	LABORATORY		4,568,897	14,249,503	18,818,400	0.113441	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY		1,177,033	1,043,761	2,220,794	0.364941	0.000000			65.00
66.00	06600	PHYSICAL THERAPY		911,689	3,046,158	3,957,847	0.451813	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY		363,955	411,676	775,631	0.528730	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY		29,081	75,245	104,326	0.768754	0.000000			68.00
68.01	03040	AUDIOLOGY		0	334,834	334,834	0.490407	0.000000			68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		1,660,903	1,930,844	3,591,747	1.238009	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		999,347	2,190,369	3,189,716	0.295475	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		3,515,714	5,710,196	9,225,910	0.253442	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION		0	660,405	660,405	0.844851	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		13,963	4,093,157	4,107,120	0.330672	0.000000			76.98
OUTPATIENT SERVICE COST CENTERS											
90.00	09000	CLINIC		946	512,601	513,547	0.348644	0.000000			90.00
91.00	09100	EMERGENCY		1,624,520	8,019,658	9,644,178	0.364827	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		77,697	345,358	423,055	0.886894	0.000000			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER		0	510,845	510,845	1.441431	0.000000			93.00
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE									113.00
200.00		Subtotal (see instructions)		26,717,754	83,416,707	110,134,461					200.00
201.00		Less Observation Beds									201.00
202.00		Total (see instructions)		26,717,754	83,416,707	110,134,461					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
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
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
68.01	03040	AUDIOLOGY	0.000000			68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
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	0.000000			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000			93.00
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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			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	932,684	9,930,913	0.093917	620,409	58,267	50.00
53.00	05300	ANESTHESIOLOGY	13,658	2,936,276	0.004651	291,809	1,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751,865	34,236,849	0.021961	1,361,781	29,906	54.00
60.00	06000	LABORATORY	339,589	18,818,400	0.018046	1,605,193	28,967	60.00
65.00	06500	RESPIRATORY THERAPY	163,095	2,220,794	0.073440	427,650	31,407	65.00
66.00	06600	PHYSICAL THERAPY	357,501	3,957,847	0.090327	212,582	19,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,120	775,631	0.094272	51,742	4,878	67.00
68.00	06800	SPEECH PATHOLOGY	6,211	104,326	0.059535	14,028	835	68.00
68.01	03040	AUDIOLOGY	43,132	334,834	0.128816	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	413,651	3,591,747	0.115167	669,311	77,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,859	3,189,716	0.021274	545,724	11,610	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	221,132	9,225,910	0.023969	1,193,634	28,610	73.00
76.97	07697	CARDIAC REHABILITATION	123,936	660,405	0.187667	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	267,541	4,107,120	0.065141	8,771	571	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,653	513,547	0.018797	0	0	90.00
91.00	09100	EMERGENCY	629,216	9,644,178	0.065243	56,747	3,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	77,789	423,055	0.183874	11,716	2,154	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	157,710	510,845	0.308724	0	0	93.00
200.00		Total (lines 50 through 199)	4,649,342	105,182,393		7,071,097	298,549	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/20/2019 4:12 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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	0	0	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	0	0	93.00
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: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/20/2019 4:12 pm	
			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	9,930,913	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,936,276	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,236,849	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	18,818,400	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,220,794	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,957,847	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	775,631	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	104,326	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	334,834	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,591,747	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,189,716	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,225,910	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	660,405	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,107,120	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	513,547	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	9,644,178	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	423,055	0.000000	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	510,845	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	105,182,393		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/20/2019 4:12 pm

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	620,409	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	291,809	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,361,781	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,605,193	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	427,650	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	212,582	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	51,742	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,028	0	0	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	669,311	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	545,724	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,193,634	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	8,771	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	56,747	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	11,716	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		7,071,097	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/20/2019 4:12 pm

			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	0.357743	0	3,098,810	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027513	0	745,821	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097799	0	10,912,918	0	0	54.00
60.00	06000	LABORATORY	0.113441	0	4,513,932	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.364941	0	372,936	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.451813	0	991,524	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.528730	0	114,581	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.768754	0	21,017	0	0	68.00
68.01	03040	AUDIOLOGY	0.490407	0	62,089	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.238009	0	576,385	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.295475	0	890,089	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253442	0	2,763,323	4,032	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.844851	0	279,582	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.330672	0	2,384,707	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.348644	0	71,226	0	0	90.00
91.00	09100	EMERGENCY	0.364827	0	3,040,818	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.886894	0	156,078	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.441431	0	348,972	0	0	93.00
200.00		Subtotal (see instructions)		0	31,344,808	4,032	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	31,344,808	4,032	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1336		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/20/2019 4:12 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,108,578	0					50.00
53.00	05300	ANESTHESIOLOGY	20,520	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,272	0					54.00
60.00	06000	LABORATORY	512,065	0					60.00
65.00	06500	RESPIRATORY THERAPY	136,100	0					65.00
66.00	06600	PHYSICAL THERAPY	447,983	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	60,582	0					67.00
68.00	06800	SPEECH PATHOLOGY	16,157	0					68.00
68.01	03040	AUDIOLOGY	30,449	0					68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	713,570	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	262,999	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700,342	1,022					73.00
76.97	07697	CARDIAC REHABILITATION	236,205	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	788,556	0					76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	24,833	0					90.00
91.00	09100	EMERGENCY	1,109,373	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	138,425	0					92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	503,019	0					93.00
200.00		Subtotal (see instructions)	7,877,028	1,022					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	7,877,028	1,022					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1336

Period:

Worksheet D

Component CCN: 14-Z336

From 07/01/2018

Part V

To 06/30/2019

Date/Time Prepared:

11/20/2019 4:12 pm

			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	0.357743	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.027513	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097799	0	0	0	0
60.00	06000	LABORATORY	0.113441	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.364941	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.451813	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.528730	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.768754	0	0	0	0
68.01	03040	AUDIOLOGY	0.490407	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.238009	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.295475	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253442	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.844851	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.330672	0	0	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.348644	0	0	0	0
91.00	09100	EMERGENCY	0.364827	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.886894	0	0	0	0
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.441431	0	0	0	0
200.00		Subtotal (see instructions)		0	0	0	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00		Net Charges (line 200 - line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1336

Period:

Worksheet D

Component CCN: 14-Z336

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/20/2019 4:12 pm

			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	
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	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
68.01	03040	AUDIOLOGY	0	0	68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
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	0	0	92.00	
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	93.00	
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: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/20/2019 4:12 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			6,188	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,542	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)			3,239	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,250	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			1,256	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			79	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)			61	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,820	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)			891	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)			891	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			155.23	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.23	20.00
21.00	Total general inpatient routine service cost (see instructions)			7,511,003	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)			12,263	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)			9,469	25.00
26.00	Total swing-bed cost (see instructions)			3,124,937	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,386,066	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)			4,386,066	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,238.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,253,724	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,253,724	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/20/2019 4:12 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	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)					2,161,880 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,415,604 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)					1,103,334 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,103,334 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,206,668 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)					303 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,238.30 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					375,205 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/20/2019 4:12 pm

		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	1,557,211	7,511,003	0.207324	375,205	77,789
91.00	Nursing School cost	0	7,511,003	0.000000	375,205	0
92.00	Allied health cost	0	7,511,003	0.000000	375,205	0
93.00	All other Medical Education	0	7,511,003	0.000000	375,205	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/20/2019 4:12 pm	
Cost Center Description		Title XVIII	Hospital	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		2,106,316		30.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.357743	620,409	221,947	50.00
53.00	05300 ANESTHESIOLOGY	0.027513	291,809	8,029	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.097799	1,361,781	133,181	54.00
60.00	06000 LABORATORY	0.113441	1,605,193	182,095	60.00
65.00	06500 RESPIRATORY THERAPY	0.364941	427,650	156,067	65.00
66.00	06600 PHYSICAL THERAPY	0.451813	212,582	96,047	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.528730	51,742	27,358	67.00
68.00	06800 SPEECH PATHOLOGY	0.768754	14,028	10,784	68.00
68.01	03040 AUDIOLOGY	0.490407	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.238009	669,311	828,613	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.295475	545,724	161,248	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253442	1,193,634	302,517	73.00
76.97	07697 CARDIAC REHABILITATION	0.844851	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.330672	8,771	2,900	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.348644	0	0	90.00
91.00	09100 EMERGENCY	0.364827	56,747	20,703	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.886894	11,716	10,391	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	1.441431	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,071,097	2,161,880	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)		7,071,097		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3
			Component CCN: 14-Z336		Date/Time Prepared: 11/20/2019 4:12 pm
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.357743	9,175	3,282
53.00	05300	ANESTHESIOLOGY	0.027513	5,930	163
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097799	171,577	16,780
60.00	06000	LABORATORY	0.113441	541,663	61,447
65.00	06500	RESPIRATORY THERAPY	0.364941	312,702	114,118
66.00	06600	PHYSICAL THERAPY	0.451813	412,137	186,209
67.00	06700	OCCUPATIONAL THERAPY	0.528730	201,037	106,294
68.00	06800	SPEECH PATHOLOGY	0.768754	6,221	4,782
68.01	03040	AUDIOLOGY	0.490407	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.238009	288,499	357,164
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.295475	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253442	743,791	188,508
76.97	07697	CARDIAC REHABILITATION	0.844851	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.330672	5,192	1,717
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.348644	0	0
91.00	09100	EMERGENCY	0.364827	214	78
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.886894	0	0
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.441431	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,698,138	1,040,542
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		2,698,138	1,040,542

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/20/2019 4:12 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,878,050	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)		7,878,050	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)		7,956,831	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)		50,547	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,375,345	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)		2,530,939	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)		2,530,939	30.00
31.00	Primary payer payments		918	31.00
32.00	Subtotal (line 30 minus line 31)		2,530,021	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)		199,036	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		129,373	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,659	36.00
37.00	Subtotal (see instructions)		2,659,394	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,659,394	40.00
40.01	Sequestration adjustment (see instructions)		53,188	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,693,684	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1,087,478	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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/20/2019 4:12 pm

		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		4,018,847		3,852,385	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	01/09/2019	56,546	01/09/2019	101,721	3.50
3.51		05/29/2019	30,468	05/29/2019	56,980	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)		-87,014		-158,701	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,931,833		3,693,684	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		44,492		1,087,478	6.02
7.00	Total Medicare program liability (see instructions)		3,887,341		2,606,206	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: 14-1336

Period:

Worksheet E-1

Component CCN: 14-Z336

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/20/2019 4:12 pm

		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		2,928,737		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	05/29/2019	101,240		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	01/09/2019	144,894		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)		-43,654		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)		2,885,083		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		295,583		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,180,666		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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/20/2019 4:12 pm

		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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet E-2	
		Component CCN: 14-Z336		Date/Time Prepared: 11/20/2019 4:12 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,228,735	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)		1,050,947	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		1,782	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3,279,682	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,279,682	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		3,279,682	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		35,385	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)		3,244,297	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)		1,970	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		1,281	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		3,245,578	0	19.00
19.01	Sequestration adjustment (see instructions)		64,912	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		2,885,083	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)		295,583	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
Comparison 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: 14-1336	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/20/2019 4:12 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			4,415,604 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)			4,415,604 4.00
5.00	Primary payer payments			7,823 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,451,937 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)			4,451,937 19.00
20.00	Deductibles (exclude professional component)			495,388 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			3,956,549 22.00
23.00	Coinsurance			8,495 23.00
24.00	Subtotal (line 22 minus line 23)			3,948,054 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			28,648 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			18,621 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,198 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,966,675 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)			3,966,675 30.00
30.01	Sequestration adjustment (see instructions)			79,334 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			3,931,833 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)			-44,492 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: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:
11/20/2019 4:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,114,809	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,585,795	0	0	0	4.00
5.00	Other receivable	395,827	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,290,531	0	0	0	6.00
7.00	Inventory	651,314	0	0	0	7.00
8.00	Prepaid expenses	193,951	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,651,165	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,052,874	0	0	0	12.00
13.00	Land improvements	1,469,318	0	0	0	13.00
14.00	Accumulated depreciation	-935,214	0	0	0	14.00
15.00	Buildings	39,624,501	0	0	0	15.00
16.00	Accumulated depreciation	-8,677,070	0	0	0	16.00
17.00	Leasehold improvements	21,000	0	0	0	17.00
18.00	Accumulated depreciation	-2,625	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	13,757,953	0	0	0	23.00
24.00	Accumulated depreciation	-9,302,777	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	56,027	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,063,987	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	3,976,416	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,976,416	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,691,568	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,228,273	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,411,380	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	20,604,929	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	2,614,220	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,858,802	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,357,291	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,311,318	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,668,609	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	59,527,411	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-4,835,843	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-4,835,843	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,691,568	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
11/20/2019 4:12 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,778,308		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,087,888				2.00
3.00	Total (sum of line 1 and line 2)		-3,866,196		0		3.00
4.00	TRANSFERS	-969,647		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)		-969,647		0		10.00
11.00	Subtotal (line 3 plus line 10)		-4,835,843		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)		-4,835,843		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	TRANSFERS		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: 14-1336

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2019 4:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,782,191		2,782,191	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,096,263		2,096,263	5.00
6.00	Swing bed - NF	117,110		117,110	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)	4,995,564		4,995,564	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,995,564		4,995,564	17.00
18.00	Ancillary services	20,216,274	75,817,473	96,033,747	18.00
19.00	Outpatient services	1,716,545	9,537,911	11,254,456	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	PRO FEES	207,708	750,688	958,396	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,136,091	86,106,072	113,242,163	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,949,799		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		44,949,799		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1336

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
11/20/2019 4:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	113,242,163	1.00
2.00	Less contractual allowances and discounts on patients' accounts	70,774,668	2.00
3.00	Net patient revenues (line 1 minus line 2)	42,467,495	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,949,799	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,482,304	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	1,155	13.00
14.00	Revenue from meals sold to employees and guests	127,946	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	4,533	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	35,300	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	40,397	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	175,018	24.00
24.01	GRANTS	10,067	24.01
25.00	Total other income (sum of lines 6-24)	394,416	25.00
26.00	Total (line 5 plus line 25)	-2,087,888	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,087,888	29.00