

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: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet S Parts I-III Date/Time Prepared: 1/27/2020 5:58 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 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.		Date: 1/27/2020 Time: 5:58 pm
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 VALLEY WEST COMMUNITY HOSPITAL (14-1340) for the cost reporting period beginning 09/01/2018 and ending 08/31/2019 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
			Part A 2.00	Part B 3.00			
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-760,043	-596,435	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	102,978	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-657,065	-596,435	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: 14-1340		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 5:58 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1302 N. MAIN STREET			PO Box:				1.00		
2.00	City: SANDWICH			State: IL		Zip Code: 60548-		County:		
		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		VALLEY WEST COMMUNITY HOSPITAL	141340	20994	1	08/02/2004	N	0	0
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		VALLEY WEST COMMUNITY HOSPITAL SWB	14Z340	20994		10/18/2018	N	0	0
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2018	08/31/2019		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1340		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 5:58 pm	
			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	
			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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
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
	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

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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.		N	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.		N	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.		N	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.		N	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.		N	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	
			1.00	2.00	
			Speech	Respiratory	
			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	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 5:58 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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	79,127	153,091	294,802	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	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		HB0640	140.00

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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: NORTHWESTERN MEMORIAL HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 131				141.00
142.00	Street: 251 E HURON STREET		PO Box:						142.00
143.00	City: CHICAGO		State: IL		Zip Code: 60611				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.					Y			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N			146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
161.10	CORF				N	N	N		161.10
161.20	OPT				N	N	N		161.20
161.30	OOT				N	N	N		161.30
161.40	OSP				N	N	N		161.40
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							N	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)					07/05/2018	10/02/2018	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 5:58 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part II Date/Time Prepared: 1/27/2020 5:58 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	12/16/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part II
Date/Time Prepared:
1/27/2020 5:58 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		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		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.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRANDON	HOFMANN		41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-766-7529	BRANDON.HOFMANN@NM.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1340

Period:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR FINANCIAL ANALYST	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
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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	21	7,665	40,359.47	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)		21	7,665	40,359.47	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	1,339.63	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	41,699.10	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OPT	99.20				0	25.20
25.30 CMHC - OOT	99.30				0	25.30
25.40 CMHC - OSP	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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: 14-1340

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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)	778	205	1,657			1.00
2.00	HMO and other (see instructions)	148	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	234	0	304			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,012	205	1,961			7.00
8.00	INTENSIVE CARE UNIT	10	15	55			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		74	304			13.00
14.00	Total (see instructions)	1,022	294	2,320	0.00	161.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OPT	0	0	0	0.00	0.00	25.20
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
25.40	CMHC - OSP	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	161.90	27.00
28.00	Observation Bed Days		0	821			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	5	56			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: 14-1340

Period:
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Date/Time Prepared:
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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	271	88	682	1.00
2.00 HMO and other (see instructions)			53	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	271	88	682	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OPT	0.00					25.20
25.30 CMHC - OOT	0.00					25.30
25.40 CMHC - OSP	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet S-10

Date/Time Prepared:
1/27/2020 5:58 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)		0.282204	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,988,567	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,815,313	5.00
6.00	Medicaid charges		20,319,943	6.00
7.00	Medicaid cost (line 1 times line 6)		5,734,369	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)	2,284,181	64,559	2,348,740
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	644,605	64,559	709,164
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	644,605	64,559	709,164
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,965,016	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		602,168	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		926,412	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,038,604	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		899,546	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,608,710	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,608,710	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,249,588	2,249,588	-681,408	1,568,180	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	712,362	712,362	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	33,093	-5,694	27,399	3,071,327	3,098,726	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,206,887	13,483,508	14,690,395	-820,885	13,869,510	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	272,327	1,712,178	1,984,505	-53,451	1,931,054	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,815	80,815	0	80,815	8.00
9.00	00900	HOUSEKEEPING	308,784	346,746	655,530	-160,124	495,406	9.00
10.00	01000	DIETARY	397,660	335,541	733,201	-589,624	143,577	10.00
11.00	01100	CAFETERIA	0	0	0	417,343	417,343	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	121,109	1,201,083	1,322,192	-22,343	1,299,849	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,085	42,503	93,588	-16,673	76,915	14.00
15.00	01500	PHARMACY	534,580	868,815	1,403,395	-823,049	580,346	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	343	343	0	343	16.00
17.00	01700	SOCIAL SERVICE	145,886	31,874	177,760	8,065	185,825	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,790,622	844,463	3,635,085	-1,304,093	2,330,992	30.00
31.00	03100	INTENSIVE CARE UNIT	171,479	34,555	206,034	-45,584	160,450	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	474,336	474,336	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,336,302	1,845,247	3,181,549	-1,077,827	2,103,722	50.00
51.00	05100	RECOVERY ROOM	119,229	28,079	147,308	-23,483	123,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	379,468	379,468	52.00
53.00	05300	ANESTHESIOLOGY	0	524,047	524,047	-2,145	521,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,158,484	1,119,288	2,277,772	-274,108	2,003,664	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	117,766	1,151,943	1,269,709	89,384	1,359,093	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	790,523	1,193,725	1,984,248	-224,242	1,760,006	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	36,997	36,997	64.00
65.00	06500	RESPIRATORY THERAPY	426,374	120,816	547,190	-104,325	442,865	65.00
66.00	06600	PHYSICAL THERAPY	146,313	32,338	178,651	-30,728	147,923	66.00
66.01	06601	O/P PHYSICAL THERAPY	322,020	98,925	420,945	12,162	433,107	66.01
69.00	06900	ELECTROCARDIOLOGY	7,332	1,881	9,213	-1,591	7,622	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	469,260	469,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	380,450	380,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	798,804	798,804	73.00
74.00	07400	RENAL DIALYSIS	0	7,627	7,627	0	7,627	74.00
76.00	03020	CLINICAL NUTRITION	24,557	5,833	30,390	-12,530	17,860	76.00
76.01	03950	SLEEP LAB	0	37,045	37,045	0	37,045	76.01
76.97	07697	CARDIAC REHABILITATION	189,849	49,911	239,760	-46,326	193,434	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	30,805	14,625	45,430	13,542	58,972	90.00
91.00	09100	EMERGENCY	1,491,251	2,857,915	4,349,166	-300,386	4,048,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,194,317	30,315,563	42,509,880	248,575	42,758,455	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	64,034	64,034	0	64,034	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	776,233	776,233	-207,148	569,085	192.00
194.00	07950	COMMUNITY WELLNESS	149,463	50,294	199,757	-41,427	158,330	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,343,780	31,206,124	43,549,904	0	43,549,904	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	150,176	1,718,356	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	561,019	1,273,381	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-143,390	2,955,336	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,385,521	7,483,989	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-303	1,930,751	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,815	8.00
9.00	00900	HOUSEKEEPING	-112	495,294	9.00
10.00	01000	DIETARY	-1,009	142,568	10.00
11.00	01100	CAFETERIA	-74,386	342,957	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-953,417	346,432	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	76,915	14.00
15.00	01500	PHARMACY	-166	580,180	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	343	16.00
17.00	01700	SOCIAL SERVICE	-15,185	170,640	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,452	2,328,540	30.00
31.00	03100	INTENSIVE CARE UNIT	-39	160,411	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	474,336	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-254,092	1,849,630	50.00
51.00	05100	RECOVERY ROOM	0	123,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-204,713	174,755	52.00
53.00	05300	ANESTHESIOLOGY	-455,758	66,144	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,470	1,975,194	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-601,704	757,389	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-307	1,759,699	60.00
64.00	06400	INTRAVENOUS THERAPY	0	36,997	64.00
65.00	06500	RESPIRATORY THERAPY	-817	442,048	65.00
66.00	06600	PHYSICAL THERAPY	-490	147,433	66.00
66.01	06601	O/P PHYSICAL THERAPY	-30,348	402,759	66.01
69.00	06900	ELECTROCARDIOLOGY	0	7,622	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	469,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	380,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	798,804	73.00
74.00	07400	RENAL DIALYSIS	0	7,627	74.00
76.00	03020	CLINICAL NUTRITION	0	17,860	76.00
76.01	03950	SLEEP LAB	0	37,045	76.01
76.97	07697	CARDIAC REHABILITATION	-450	192,984	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	58,972	90.00
91.00	09100	EMERGENCY	-2,038,416	2,010,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OPT	0	0	99.20
99.30	09930	OOT	0	0	99.30
99.40	09940	OSP	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,480,350	32,278,105	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-16,160	47,874	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-32,919	536,166	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.00	07950	COMMUNITY WELLNESS	0	158,330	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,529,429	33,020,475	200.00

RECLASSIFICATIONS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/27/2020 5:58 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	798,804		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	798,804		
	B - NURSERY / DELIVERY & LABOR COSTS					
1.00	NURSERY	43.00	465,676	8,660		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	171,565	3,190		2.00
	TOTALS		637,241	11,850		
	C - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	469,260		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
	TOTALS		0	469,260		
	D - EQUIPMENT LEASES					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	60,578		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	60,578		
	E - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	296,781	120,562		1.00
	TOTALS		296,781	120,562		
	F - INTEREST EXPENSE					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	G - EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	658,215		1.00
	TOTALS		0	658,215		
	H - CONTINUITY OF CARE					
1.00	SOCIAL SERVICE	17.00	89,905	21,198		1.00
	TOTALS		89,905	21,198		
	I - ROUTINE DIABETES					
1.00	ADULTS & PEDIATRICS	30.00	6,697	0		1.00
	TOTALS		6,697	0		
	J - ICU OBSERVATION					
1.00	ADULTS & PEDIATRICS	30.00	15,158	53		1.00
	TOTALS		15,158	53		
	K - MOB RECLASS					
1.00	RADIOLOGY - THERAPEUTIC	55.00	0	119,188		1.00
2.00	O/P PHYSICAL THERAPY	66.01	0	86,248		2.00
3.00	CLINIC	90.00	0	22,171		3.00
	TOTALS		0	227,607		
	L - SOCIAL SERVICE					
1.00	EMERGENCY	91.00	80,432	11,389		1.00
	TOTALS		80,432	11,389		
	M - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	380,450		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	380,450		
	N - MEDICAL DIRECTOR RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	0	3,563		1.00
2.00	OPERATING ROOM	50.00	0	241,050		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	40,613	164,100		3.00
4.00	RESPIRATORY THERAPY	65.00	0	3,562		4.00
	TOTALS		40,613	412,275		
	O - VW MOB BUILDING DEPRECIATION					
1.00	RADIOLOGY - THERAPEUTIC	55.00	0	3,758		1.00
2.00	O/P PHYSICAL THERAPY	66.01	0	2,719		2.00
3.00	CLINIC	90.00	0	698		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,018		4.00
	TOTALS		0	23,193		

RECLASSIFICATIONS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	P - VW MOB EQUIPMENT DEPRECIATION				
1.00	RADIOLOGY - THERAPEUTIC	55.00	0	1,042	1.00
2.00	O/P PHYSICAL THERAPY	66.01	0	754	2.00
3.00	CLINIC	90.00	0	194	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,441	4.00
	TOTALS		0	6,431	
	Q - ARROWHEAD OP PT MOV EQ DEPRECIATION				
1.00		0.00	0	0	1.00
	TOTALS		0	0	
	R - IV SOLUTIONS				
1.00	INTRAVENOUS THERAPY	64.00	0	36,997	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
	TOTALS		0	36,997	
	S - DIRECTLY ASSIGNED BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,071,327	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
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
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	3,071,327	
	T - PLANT OPERATIONS RECLASS				
1.00	OPERATION OF PLANT	7.00	0	21,970	1.00
	TOTALS		0	21,970	
500.00	Grand Total: Increases		1,166,827	6,332,159	500.00

RECLASSIFICATIONS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	666,412	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	798	0		2.00
3.00	OPERATING ROOM	50.00	0	125,082	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	1,933	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	788	0		5.00
6.00	LABORATORY	60.00	0	5	0		6.00
7.00	EMERGENCY	91.00	0	3,786	0		7.00
	TOTALS		0	798,804			
	B - NURSERY / DELIVERY & LABOR COSTS						
1.00	ADULTS & PEDIATRICS	30.00	637,241	11,850	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		637,241	11,850			
	C - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	8,154	0		1.00
2.00	OPERATING ROOM	50.00	0	456,639	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	212	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,829	0		4.00
5.00	EMERGENCY	91.00	0	2,426	0		5.00
	TOTALS		0	469,260			
	D - EQUIPMENT LEASES						
1.00	PHARMACY	15.00	0	58,096	10		1.00
2.00	OPERATING ROOM	50.00	0	1,050	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	1,432	0		3.00
	TOTALS		0	60,578			
	E - CAFETERIA RECLASS						
1.00	DIETARY	10.00	296,781	120,562	0		1.00
	TOTALS		296,781	120,562			
	F - INTEREST EXPENSE						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	G - EQUIPMENT DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	658,215	9		1.00
	TOTALS		0	658,215			
	H - CONTINUITY OF CARE						
1.00	ADMINISTRATIVE & GENERAL	5.00	89,905	21,198	0		1.00
	TOTALS		89,905	21,198			
	I - ROUTINE DIABETES						
1.00	CLINICAL NUTRITION	76.00	6,697	0	0		1.00
	TOTALS		6,697	0			
	J - ICU OBSERVATION						
1.00	INTENSIVE CARE UNIT	31.00	15,158	53	0		1.00
	TOTALS		15,158	53			
	K - MOB RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	227,607	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	227,607			
	L - SOCIAL SERVICE						
1.00	SOCIAL SERVICE	17.00	80,432	11,389	0		1.00
	TOTALS		80,432	11,389			
	M - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	379,939	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	392	0		2.00
3.00	EMERGENCY	91.00	0	119	0		3.00
	TOTALS		0	380,450			
	N - MEDICAL DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	40,613	412,275	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		40,613	412,275			
	O - VW MOB BUILDING DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	23,193	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	23,193			
	P - VW MOB EQUIPMENT DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,431	9		1.00
2.00		0.00	0	0	0		2.00

RECLASSIFICATIONS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	6,431			
Q - ARROWHEAD OP PT MOV EQ DEPRECIATION							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
R - IV SOLUTIONS							
1.00	ADULTS & PEDIATRICS	30.00	0	674	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	18	0		2.00
3.00	OPERATING ROOM	50.00	0	36,077	0		3.00
4.00	RECOVERY ROOM	51.00	0	1	0		4.00
5.00	EMERGENCY	91.00	0	227	0		5.00
	TOTALS		0	36,997			
S - DIRECTLY ASSIGNED BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	234,924	0		1.00
2.00	OPERATION OF PLANT	7.00	0	75,421	0		2.00
3.00	HOUSEKEEPING	9.00	0	160,124	0		3.00
4.00	DIETARY	10.00	0	172,281	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	22,343	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,673	0		6.00
7.00	PHARMACY	15.00	0	98,541	0		7.00
8.00	SOCIAL SERVICE	17.00	0	11,217	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	667,284	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	33,918	0		10.00
11.00	OPERATING ROOM	50.00	0	320,090	0		11.00
12.00	RECOVERY ROOM	51.00	0	23,482	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	272,928	0		13.00
14.00	RADIOLOGY - THERAPEUTIC	55.00	0	34,604	0		14.00
15.00	LABORATORY	60.00	0	224,237	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	104,626	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	30,728	0		17.00
18.00	O/P PHYSICAL THERAPY	66.01	0	77,559	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,591	0		19.00
20.00	CLINICAL NUTRITION	76.00	0	5,833	0		20.00
21.00	CARDIAC REHABILITATION	76.97	0	46,326	0		21.00
22.00	CLINIC	90.00	0	9,521	0		22.00
23.00	EMERGENCY	91.00	0	385,649	0		23.00
24.00	COMMUNITY WELLNESS	194.00	0	41,427	0		24.00
	TOTALS		0	3,071,327			
T - PLANT OPERATIONS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,970	0		1.00
	TOTALS		0	21,970			
500.00	Grand Total: Decreases		1,166,827	6,332,159			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,560,000	234,000	0	234,000	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,125,867	1,421,273	0	1,421,273	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,980,652	1,069,955	0	1,069,955	54,910	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,666,519	2,725,228	0	2,725,228	54,910	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,666,519	2,725,228	0	2,725,228	54,910	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,794,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	20,547,140	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,995,697	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	28,336,837	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	28,336,837	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part II
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT	2,249,588	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,249,588	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,249,588				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,249,588				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part III
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT	20,547,140	0	20,547,140	0.774153	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,995,010	687	5,994,323	0.225847	0	2.00
3.00	Total (sum of lines 1-2)	26,542,150	687	26,541,463	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,718,356	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,212,803	60,578	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,931,159	60,578	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,718,356	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,273,381	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,991,737	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
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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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-204	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,614,477			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-360	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-4,374,934			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-74,386	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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 - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW 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 *** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1340

Period:
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Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	CORP BILLING MISC INCOME	B	-166	PHARMACY		15.00	0	33.00
34.00	CORP BILLING MISC INCOME	B	-1,168	ADULTS & PEDIATRICS		30.00	0	34.00
35.00	MOI MRI SPACE RENTAL	B	-39,313	RADIOLOGY-DIAGNOSTIC		54.00	0	35.00
36.00	CORP BILLING MISC INCOME	B	-298	RADIOLOGY-DIAGNOSTIC		54.00	0	36.00
37.00	CORP BILLING MISC INCOME	B	-99	RADIOLOGY-DIAGNOSTIC		54.00	0	37.00
38.00	CORP BILLING MISC INCOME	B	-59	LABORATORY		60.00	0	38.00
39.00	CORP BILLING MISC INCOME	B	-14	LABORATORY		60.00	0	39.00
39.01	CORP BILLING MISC INCOME	B	-728	RESPIRATORY THERAPY		65.00	0	39.01
39.02	OTHER MISC INCOME	B	-1,585	O/P PHYSICAL THERAPY		66.01	0	39.02
39.03	OTHER MISC INCOME	B	-450	CARDIAC REHABILITATION		76.97	0	39.03
40.00	PROVIDER MEDICAID ASSESSMENT	A	-1,163,176	ADMINISTRATIVE & GENERAL		5.00	0	40.00
41.00	LOBBYING PORTION OF DUES	A	-13,149	ADMINISTRATIVE & GENERAL		5.00	0	41.00
41.01	LOBBYING PORTION OF DUES	A	-2,270	ADMINISTRATIVE & GENERAL		5.00	0	41.01
42.00	PROPERTY TAX	A	-1,992	ADMINISTRATIVE & GENERAL		5.00	0	42.00
43.00	PROPERTY TAX	A	-4,200	ADMINISTRATIVE & GENERAL		5.00	0	43.00
44.00	PROPERTY TAX	A	-9,300	PHYSICIANS' PRIVATE OFFICES		192.00	0	44.00
44.01	DEPRECIATION TO MEDICRE STRAIGHTLINE	A	-114,895	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	44.01
44.02	DEPRECIATION TO MEDICRE STRAIGHTLINE	A	35,576	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	44.02
44.03	CAPITALIZED DEPRECIATION	A	-433	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	44.03
44.04	NON-ALLOWABLE DEPRECIATION	A	-1,012	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	44.04
44.05	NON-ALLOWABLE DEPRECIATION	A	-7,928	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	44.05
44.06	CONTRIBUTIONS	A	-4,574	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190.00	0	44.06
44.07	SCHOLARSHIPS	A	-11,586	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190.00	0	44.07
44.08	COMMUNITY SUPPORT	A	-8,927	ADMINISTRATIVE & GENERAL		5.00	0	44.08
44.09	CABLE	A	-491	ADULTS & PEDIATRICS		30.00	0	44.09
44.10	CABLE	A	-2,661	O/P PHYSICAL THERAPY		66.01	0	44.10
45.00	INTANGIBLE	A	-63	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	45.00
45.01	REMOVE LOSS ON DISPOSITION OF ASSET	A	1,286	DIETARY		10.00	0	45.01
45.02	REMOVE LOSS ON DISPOSITION OF ASSET	A	-497	ADULTS & PEDIATRICS		30.00	0	45.02
45.03	REMOVE LOSS ON DISPOSITION OF ASSET	A	-39	INTENSIVE CARE UNIT		31.00	0	45.03
45.04	REMOVE LOSS ON DISPOSITION OF ASSET	A	-9,500	OPERATING ROOM		50.00	0	45.04
45.05	REMOVE LOSS ON DISPOSITION OF ASSET	A	-490	PHYSICAL THERAPY		66.00	0	45.05
45.06	REMOVE LOSS ON DISPOSITION OF ASSET	A	-408	EMERGENCY		91.00	0	45.06
45.07	PHYSICIAN MALPRACTICE	A	-11,858	ADMINISTRATIVE & GENERAL		5.00	0	45.07
45.08	SALES TAX EXPENSE	A	-127	ADMINISTRATIVE & GENERAL		5.00	0	45.08
45.09	NON-ALLOWABLE MISC EXPENSE	A	-6,371	ADMINISTRATIVE & GENERAL		5.00	0	45.09
45.10	NON-ALLOWABLE MISC EXPENSE	A	-33	NURSING ADMINISTRATION		13.00	0	45.10
45.11	NON-ALLOWABLE MISC EXPENSE	A	-206	ADULTS & PEDIATRICS		30.00	0	45.11
45.12	NON-ALLOWABLE MISC EXPENSE	A	-215	LABORATORY		60.00	0	45.12
45.13	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0			0.00	0	45.13
45.14	MEALS ON WHEELS	A	-2,236	DIETARY		10.00	0	45.14
45.15	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0			0.00	0	45.15
45.16	OTHER COMMUNITY PROGRAM COSTS	A	-26,087	O/P PHYSICAL THERAPY		66.01	0	45.16
45.17	OTHER COMMUNITY PROGRAM COSTS	A	-6,479	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.17
45.18	AMBULANCE COSTS	A	-15,185	SOCIAL SERVICE		17.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0			0.00	0	45.19
45.20	BAD DEBT EXPENSE	A	-420	PHYSICIANS' PRIVATE OFFICES		192.00	0	45.20
45.21	NON-ALLOWABLE OVER SHORT	A	-47	ADMINISTRATIVE & GENERAL		5.00	0	45.21
45.22	VACANT PROPERTY EXPENSE	A	-6,100	ADMINISTRATIVE & GENERAL		5.00	0	45.22
45.23	NONALLOWABLE MARKETING & PROMOTION	A	-172	ADMINISTRATIVE & GENERAL		5.00	0	45.23

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/27/2020 5:58 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	
45.24	NONALLOWABLE MARKETING & PROMOTION	A	-99	OPERATION OF PLANT	7.00	0	45.24
45.25	NONALLOWABLE MARKETING & PROMOTION	A	-112	HOUSEKEEPING	9.00	0	45.25
45.26	NONALLOWABLE MARKETING & PROMOTION	A	-59	DIETARY	10.00	0	45.26
45.27	NONALLOWABLE MARKETING & PROMOTION	A	-235	NURSING ADMINISTRATION	13.00	0	45.27
45.28	NONALLOWABLE MARKETING & PROMOTION	A	-90	ADULTS & PEDIATRICS	30.00	0	45.28
45.29	NONALLOWABLE MARKETING & PROMOTION	A	-186	OPERATING ROOM	50.00	0	45.29
45.30	NONALLOWABLE MARKETING & PROMOTION	A	-400	RADIOLOGY-DIAGNOSTIC	54.00	0	45.30
45.31	NONALLOWABLE MARKETING & PROMOTION	A	-19	LABORATORY	60.00	0	45.31
45.32	NONALLOWABLE MARKETING & PROMOTION	A	-89	RESPIRATORY THERAPY	65.00	0	45.32
45.33	NONALLOWABLE MARKETING & PROMOTION	A	-15	O/P PHYSICAL THERAPY	66.01	0	45.33
45.34	NONALLOWABLE MARKETING & PROMOTION	A	-420	EMERGENCY	91.00	0	45.34
45.35	NON VALLEY WEST COST	A	-1,800	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.35
45.36	NONALLOWABLE SPONSORSHIP A&G COST	A	-10,000	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.36
45.37	NON VALLEY WEST COST	A	-2,463	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.37
45.38	NON VALLEY WEST COST	A	-8,936	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,529,429				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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-1

Date/Time Prepared:
1/27/2020 5:58 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	NMHC HOME OFFICE ADMINISTRAT	5,672,297	9,978,775	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	NMHC HOME OFFICE CAPITAL	266,579	0	2.00
3.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	NMHC HOME OFFICE CAPITAL	533,371	0	3.00
4.00	13.00	NURSING ADMINISTRATION	NMHC HOME OFFICE QUALITY	126,646	0	4.00
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	NMHC HOME OFFICE BENEFITS	-134,398	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	IC CAPTIVE RISK INSURANCE	385,917	385,917	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	WEST REGION COSTS	7,957	17,836	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	SUBSIDY CHARGE	0	850,775	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	CONTRACTED SERVICE	1,294	1,294	4.06
4.07	55.00	RADIOLOGY - THERAPEUTIC	IC LEASED EE MD	601,704	601,704	4.07
4.08	60.00	LABORATORY	CORPORATE EXPENSE	7,105	7,105	4.08
4.09	60.00	LABORATORY	PURCHASED LAB	186,804	186,804	4.09
4.10	65.00	RESPIRATORY THERAPY	PURCHASED SERVICE	293	293	4.10
4.11	65.00	RESPIRATORY THERAPY	CONTRACTED SERVICE	2,367	2,367	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER FRINGES	2,182,934	2,182,934	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	-74,590	-74,590	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	63,438	63,438	4.14
4.15	192.00	PHYSICIANS' PRIVATE OFFICES	LEASED PROPERTIES FEES	10,452	10,452	4.15
4.16	192.00	PHYSICIANS' PRIVATE OFFICES	LEASED PROPERTIES FEES	23,666	23,666	4.16
5.00	0		0	9,863,836	14,238,770	5.00

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

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

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

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

6.00	B		100.00	NMHC	100.00	6.00
7.00	B		100.00	CDH	100.00	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-1

Date/Time Prepared:
1/27/2020 5:58 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	-4,306,478	0		1.00
2.00	266,579	9		2.00
3.00	533,371	9		3.00
4.00	126,646	0		4.00
4.02	-134,398	0		4.02
4.03	0	0		4.03
4.04	-9,879	0		4.04
4.05	-850,775	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
5.00	-4,374,934			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HEALTHCARE		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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-2

Date/Time Prepared:
1/27/2020 5:58 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	13.00	AGGREGATE-NURSING ADMINISTRATION	1,079,795	1,079,795	0	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	455,758	455,758	0	0	0	2.00
3.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	-12,000	-12,000	0	0	0	3.00
4.00	55.00	AGGREGATE-RADIOLOGY - THERAPEUTIC	601,704	601,704	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	3,356	3,356	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	65,000	65,000	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	176,050	176,050	0	0	0	7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	40,613	40,613	0	0	0	8.00
9.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	164,100	164,100	0	0	0	9.00
10.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	2,513	2,513	0	0	0	10.00
11.00	91.00	AGGREGATE-EMERGENCY	2,312,281	2,037,588	274,693	0	0	11.00
200.00			4,889,170	4,614,477	274,693	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	55.00	AGGREGATE-RADIOLOGY - THERAPEUTIC	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	8.00
9.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	9.00
10.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0	0	10.00
11.00	91.00	AGGREGATE-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	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	1,079,795		1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	455,758		2.00
3.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	-12,000		3.00
4.00	55.00	AGGREGATE-RADIOLOGY - THERAPEUTIC	0	0	0	601,704		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	3,356		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	65,000		6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	176,050		7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	40,613		8.00
9.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	164,100		9.00
10.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	2,513		10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	0	2,037,588		11.00
200.00			0	0	0	4,614,477		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,718,356	1,718,356			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,273,381	1,273,381			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,955,336	10,523	7,798	2,973,657	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,483,989	165,838	122,894	259,998	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,930,751	277,513	205,648	65,781	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,815	11,780	8,729	0	8.00
9.00	00900	HOUSEKEEPING	495,294	35,990	26,670	74,587	9.00
10.00	01000	DIETARY	142,568	18,264	13,535	24,367	10.00
11.00	01100	CAFETERIA	342,957	53,694	39,790	71,688	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	346,432	13,530	10,026	29,254	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	76,915	62,534	46,341	12,340	14.00
15.00	01500	PHARMACY	580,180	25,512	18,905	129,128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343	6,933	5,138	0	16.00
17.00	01700	SOCIAL SERVICE	170,640	0	0	37,527	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,328,540	264,138	195,738	525,429	30.00
31.00	03100	INTENSIVE CARE UNIT	160,411	38,795	28,749	37,759	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	474,336	9,177	6,801	112,485	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,849,630	226,285	167,688	322,785	50.00
51.00	05100	RECOVERY ROOM	123,825	35,878	26,587	28,800	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174,755	12,610	9,345	51,252	52.00
53.00	05300	ANESTHESIOLOGY	66,144	7,472	5,537	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,975,194	156,751	116,159	279,833	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	757,389	0	0	28,446	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,759,699	59,169	43,847	190,952	60.00
64.00	06400	INTRAVENOUS THERAPY	36,997	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	442,048	14,360	10,642	102,991	65.00
66.00	06600	PHYSICAL THERAPY	147,433	18,309	13,568	35,342	66.00
66.01	06601	O/P PHYSICAL THERAPY	402,759	0	0	77,784	66.01
69.00	06900	ELECTROCARDIOLOGY	7,622	5,026	3,725	1,771	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	469,260	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	380,450	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	798,804	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,627	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	17,860	0	0	4,314	76.00
76.01	03950	SLEEP LAB	37,045	13,732	10,176	0	76.01
76.97	07697	CARDIAC REHABILITATION	192,984	23,492	17,409	45,858	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	58,972	0	0	7,441	90.00
91.00	09100	EMERGENCY	2,010,364	92,152	68,289	379,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,278,105	1,659,457	1,229,734	2,937,554	32,139,456	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,874	15,078	11,174	0	74,126	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	536,166	6,978	5,171	0	548,315	192.00
194.00	07950	COMMUNITY WELLNESS	158,330	36,843	27,302	36,103	258,578	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,020,475	1,718,356	1,273,381	2,973,657	33,020,475	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,032,719					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	797,137	0	3,276,830			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,572	0	30,527	164,423		8.00
9.00	00900	HOUSEKEEPING	203,340	0	93,267	0	929,148	9.00
10.00	01000	DIETARY	63,886	0	47,331	0	13,948	10.00
11.00	01100	CAFETERIA	163,346	0	139,144	0	41,003	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	128,343	0	35,062	0	10,332	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,692	0	162,054	0	47,754	14.00
15.00	01500	PHARMACY	242,297	0	66,112	0	19,482	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,991	0	17,967	0	5,295	16.00
17.00	01700	SOCIAL SERVICE	66,919	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,065,295	0	684,496	48,177	201,712	30.00
31.00	03100	INTENSIVE CARE UNIT	85,418	0	100,535	1,038	29,626	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	193,779	0	23,782	5,615	7,008	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	825,006	0	586,405	21,442	172,804	50.00
51.00	05100	RECOVERY ROOM	69,144	0	92,976	0	27,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	79,711	0	32,678	2,068	9,630	52.00
53.00	05300	ANESTHESIOLOGY	25,445	0	19,363	1,905	5,706	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	812,646	0	406,209	21,523	119,703	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	252,619	0	0	214	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	660,184	0	153,332	0	45,184	60.00
64.00	06400	INTRAVENOUS THERAPY	11,893	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	183,249	0	37,214	89	10,966	65.00
66.00	06600	PHYSICAL THERAPY	69,003	0	47,447	30	13,982	66.00
66.01	06601	O/P PHYSICAL THERAPY	154,478	0	0	5,068	0	66.01
69.00	06900	ELECTROCARDIOLOGY	5,833	0	13,025	176	3,838	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,851	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,302	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256,788	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,452	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	7,128	0	0	0	0	76.00
76.01	03950	SLEEP LAB	19,594	0	35,585	805	10,486	76.01
76.97	07697	CARDIAC REHABILITATION	89,928	0	60,879	306	17,940	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	21,350	0	0	142	0	90.00
91.00	09100	EMERGENCY	819,882	0	238,807	55,825	70,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,749,501	0	3,124,197	164,423	884,169	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,829	0	39,074	0	11,515	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	176,265	0	18,083	0	5,329	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
194.00	07950	COMMUNITY WELLNESS	83,124	0	95,476	0	28,135	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,032,719	0	3,276,830	164,423	929,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	323,899					10.00
11.00	01100	CAFETERIA	0	851,622				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	7,040	0	580,019		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,393	0	0	478,023	14.00
15.00	01500	PHARMACY	0	31,125	0	0	4,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,711	0	0	117	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	308,939	181,898	0	212,018	39,046	30.00
31.00	03100	INTENSIVE CARE UNIT	14,960	8,767	0	10,219	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	37,472	0	43,677	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	109,021	0	127,073	6,455	50.00
51.00	05100	RECOVERY ROOM	0	7,543	0	8,792	1,145	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,808	0	16,094	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	5,516	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,153	0	0	5,737	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	12,637	0	0	1,792	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	83,626	0	0	34,912	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	6,867	64.00
65.00	06500	RESPIRATORY THERAPY	0	37,079	0	0	201	65.00
66.00	06600	PHYSICAL THERAPY	0	10,534	0	0	351	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	27,884	0	0	1,620	66.01
69.00	06900	ELECTROCARDIOLOGY	0	593	0	0	20	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	179,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	145,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	742	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	1,603	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	14,875	0	0	173	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	3,638	0	0	44	90.00
91.00	09100	EMERGENCY	0	139,111	0	162,146	43,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	323,899	836,511	0	580,019	476,988	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	15,111	0	0	1,035	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	323,899	851,622	0	580,019	478,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,117,564					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,667				16.00
17.00	01700	SOCIAL SERVICE	0	0	281,914			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,865	268,893	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	84	13,021	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	164	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,449	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	203	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	231	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	841	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,492	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	479,746	1,341	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,163	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	956	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	765	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	170	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	397	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	24	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,955	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	873	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	637,818	4,191	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	7	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	7	0	0	0	76.00
76.01	03950	SLEEP LAB	0	120	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	130	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	69	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,170	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,117,564	39,667	281,914	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	0	0	194.00
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)	1,117,564	39,667	281,914	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	6,327,184	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	529,382	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	914,296	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,418,043	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	422,291	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	402,182	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	137,929	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,998,400	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	1,534,184	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	3,035,068	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	56,713	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	839,604	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	356,169	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	0	669,990	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,653	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	801,216	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	648,871	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,698,343	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	10,086	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	30,912	0	76.00
76.01	03950	SLEEP LAB	0	0	0	127,543	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	463,974	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	91,656	0	90.00
91.00	09100	EMERGENCY	0	0	0	4,086,791	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00	23.00	24.00	25.00	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	31,642,480	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	148,544	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	747,992	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	481,459	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	33,020,475	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	6,327,184	30.00
31.00	03100	INTENSIVE CARE UNIT	529,382	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	914,296	43.00
45.00	04500	NURSING FACILITY	0	45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,418,043	50.00
51.00	05100	RECOVERY ROOM	422,291	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	402,182	52.00
53.00	05300	ANESTHESIOLOGY	137,929	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,400	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,534,184	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	3,035,068	60.00
64.00	06400	INTRAVENOUS THERAPY	56,713	64.00
65.00	06500	RESPIRATORY THERAPY	839,604	65.00
66.00	06600	PHYSICAL THERAPY	356,169	66.00
66.01	06601	O/P PHYSICAL THERAPY	669,990	66.01
69.00	06900	ELECTROCARDIOLOGY	41,653	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	801,216	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	648,871	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,698,343	73.00
74.00	07400	RENAL DIALYSIS	10,086	74.00
76.00	03020	CLINICAL NUTRITION	30,912	76.00
76.01	03950	SLEEP LAB	127,543	76.01
76.97	07697	CARDIAC REHABILITATION	463,974	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	91,656	90.00
91.00	09100	EMERGENCY	4,086,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OPT	0	99.20
99.30	09930	OOT	0	99.30
99.40	09940	OSP	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,642,480	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	148,544	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	747,992	192.00
194.00	07950	COMMUNITY WELLNESS	481,459	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	33,020,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,523	7,798	18,321	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,500	165,838	122,894	308,232	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	277,513	205,648	483,161	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,780	8,729	20,509	8.00
9.00	00900	HOUSEKEEPING	0	35,990	26,670	62,660	9.00
10.00	01000	DIETARY	1,459	18,264	13,535	33,258	10.00
11.00	01100	CAFETERIA	4,291	53,694	39,790	97,775	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	13,530	10,026	23,556	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62,534	46,341	108,875	14.00
15.00	01500	PHARMACY	0	25,512	18,905	44,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,933	5,138	12,071	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	264,138	195,738	459,876	30.00
31.00	03100	INTENSIVE CARE UNIT	0	38,795	28,749	67,544	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	9,177	6,801	15,978	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	226,285	167,688	393,973	50.00
51.00	05100	RECOVERY ROOM	0	35,878	26,587	62,465	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,610	9,345	21,955	52.00
53.00	05300	ANESTHESIOLOGY	0	7,472	5,537	13,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	156,751	116,159	272,910	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	85,344	0	0	85,344	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	59,169	43,847	103,016	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,360	10,642	25,002	65.00
66.00	06600	PHYSICAL THERAPY	0	18,309	13,568	31,877	66.00
66.01	06601	O/P PHYSICAL THERAPY	66,033	0	0	66,033	66.01
69.00	06900	ELECTROCARDIOLOGY	0	5,026	3,725	8,751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	13,732	10,176	23,908	76.01
76.97	07697	CARDIAC REHABILITATION	0	23,492	17,409	40,901	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	15,875	0	0	15,875	90.00
91.00	09100	EMERGENCY	0	92,152	68,289	160,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	192,502	1,659,457	1,229,734	3,081,693	18,099	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,078	11,174	26,252	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	363,775	6,978	5,171	375,924	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	36,843	27,302	64,145	222	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	556,277	1,718,356	1,273,381	3,548,014	18,321	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	309,834					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	30,746	0	514,312			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,256	0	4,791	26,556		8.00
9.00	00900	HOUSEKEEPING	7,843	0	14,639	0	85,601	9.00
10.00	01000	DIETARY	2,464	0	7,429	0	1,285	10.00
11.00	01100	CAFETERIA	6,300	0	21,839	0	3,778	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,950	0	5,503	0	952	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,457	0	25,435	0	4,400	14.00
15.00	01500	PHARMACY	9,345	0	10,377	0	1,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	154	0	2,820	0	488	16.00
17.00	01700	SOCIAL SERVICE	2,581	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,100	0	107,435	7,781	18,582	30.00
31.00	03100	INTENSIVE CARE UNIT	3,295	0	15,779	168	2,729	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	7,474	0	3,733	907	646	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,821	0	92,039	3,463	15,920	50.00
51.00	05100	RECOVERY ROOM	2,667	0	14,593	0	2,524	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,074	0	5,129	334	887	52.00
53.00	05300	ANESTHESIOLOGY	981	0	3,039	308	526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,344	0	63,756	3,476	11,028	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	9,744	0	0	35	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	25,463	0	24,066	0	4,163	60.00
64.00	06400	INTRAVENOUS THERAPY	459	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,068	0	5,841	14	1,010	65.00
66.00	06600	PHYSICAL THERAPY	2,661	0	7,447	5	1,288	66.00
66.01	06601	O/P PHYSICAL THERAPY	5,958	0	0	819	0	66.01
69.00	06900	ELECTROCARDIOLOGY	225	0	2,044	28	354	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,818	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,717	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,904	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	95	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	275	0	0	0	0	76.00
76.01	03950	SLEEP LAB	756	0	5,585	130	966	76.01
76.97	07697	CARDIAC REHABILITATION	3,469	0	9,555	49	1,653	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	823	0	0	23	0	90.00
91.00	09100	EMERGENCY	31,623	0	37,482	9,016	6,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	298,910	0	490,356	26,556	81,457	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	919	0	6,133	0	1,061	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,799	0	2,838	0	491	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
194.00	07950	COMMUNITY WELLNESS	3,206	0	14,985	0	2,592	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	309,834	0	514,312	26,556	85,601	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	44,586					10.00
11.00	01100	CAFETERIA	0	130,134				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,076	0	36,217		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	977	0	0	142,220	14.00
15.00	01500	PHARMACY	0	4,756	0	0	1,435	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,026	0	0	35	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,527	27,793	0	13,238	11,617	30.00
31.00	03100	INTENSIVE CARE UNIT	2,059	1,340	0	638	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	5,726	0	2,727	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,659	0	7,935	1,920	50.00
51.00	05100	RECOVERY ROOM	0	1,153	0	549	341	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,110	0	1,005	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,540	0	0	1,707	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,931	0	0	533	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,779	0	0	10,387	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	2,043	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,666	0	0	60	65.00
66.00	06600	PHYSICAL THERAPY	0	1,610	0	0	104	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	4,261	0	0	482	66.01
69.00	06900	ELECTROCARDIOLOGY	0	91	0	0	6	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	53,300	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	43,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	221	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	245	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	2,273	0	0	51	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	556	0	0	13	90.00
91.00	09100	EMERGENCY	0	21,257	0	10,125	12,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,586	127,825	0	36,217	141,912	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	2,309	0	0	308	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	44,586	130,134	0	36,217	142,220	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	72,920					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,533				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,873			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,125	3,694			30.00
31.00	03100	INTENSIVE CARE UNIT	0	33	179			31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0			41.00
42.00	04200	SUBPROVIDER	0	0	0			42.00
43.00	04300	NURSERY	0	65	0			43.00
45.00	04500	NURSING FACILITY	0	0	0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,354	0			50.00
51.00	05100	RECOVERY ROOM	0	80	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	91	0			52.00
53.00	05300	ANESTHESIOLOGY	0	330	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,684	0			54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	31,303	526	0			55.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0			59.00
60.00	06000	LABORATORY	0	1,635	0			60.00
64.00	06400	INTRAVENOUS THERAPY	0	375	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	300	0			65.00
66.00	06600	PHYSICAL THERAPY	0	67	0			66.00
66.01	06601	O/P PHYSICAL THERAPY	0	156	0			66.01
69.00	06900	ELECTROCARDIOLOGY	0	9	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	768	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	343	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,617	1,646	0			73.00
74.00	07400	RENAL DIALYSIS	0	3	0			74.00
76.00	03020	CLINICAL NUTRITION	0	3	0			76.00
76.01	03950	SLEEP LAB	0	47	0			76.01
76.97	07697	CARDIAC REHABILITATION	0	51	0			76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	27	0			90.00
91.00	09100	EMERGENCY	0	2,815	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0			92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
99.30	09930	OOT	0	0	0			99.30
99.40	09940	OSP	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE	0	0	0			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,920	15,533	3,873	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,920	15,533	3,873	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
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Date/Time Prepared:
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Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
		21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS			738,009	0	30.00
31.00	03100	INTENSIVE CARE UNIT			93,997	0	31.00
41.00	04100	SUBPROVIDER - IRF			0	0	41.00
42.00	04200	SUBPROVIDER			0	0	42.00
43.00	04300	NURSERY			37,949	0	43.00
45.00	04500	NURSING FACILITY			0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM			567,072	0	50.00
51.00	05100	RECOVERY ROOM			84,549	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			34,901	0	52.00
53.00	05300	ANESTHESIOLOGY			19,834	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			404,169	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC			129,591	0	55.00
57.00	05700	CT SCAN			0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)			0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION			0	0	59.00
60.00	06000	LABORATORY			182,685	0	60.00
64.00	06400	INTRAVENOUS THERAPY			2,877	0	64.00
65.00	06500	RESPIRATORY THERAPY			45,595	0	65.00
66.00	06600	PHYSICAL THERAPY			45,277	0	66.00
66.01	06601	O/P PHYSICAL THERAPY			78,188	0	66.01
69.00	06900	ELECTROCARDIOLOGY			11,519	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			59,886	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			48,273	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			53,388	0	73.00
74.00	07400	RENAL DIALYSIS			98	0	74.00
76.00	03020	CLINICAL NUTRITION			550	0	76.00
76.01	03950	SLEEP LAB			31,392	0	76.01
76.97	07697	CARDIAC REHABILITATION			58,284	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC			0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			0	0	89.00
90.00	09000	CLINIC			17,363	0	90.00
91.00	09100	EMERGENCY			294,384	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF			0	0	99.10
99.20	09920	OPT			0	0	99.20
99.30	09930	OOT			0	0	99.30
99.40	09940	OSP			0	0	99.40
101.00	10100	HOME HEALTH AGENCY			0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION			0	0	109.00
110.00	11000	INTESTINAL ACQUISITION			0	0	110.00
111.00	11100	ISLET ACQUISITION			0	0	111.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00	23.00	24.00	25.00	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	3,039,830	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				34,365	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				386,052	0	192.00
194.00	07950	COMMUNITY WELLNESS				87,767	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	3,548,014	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	738,009	30.00
31.00	03100	INTENSIVE CARE UNIT	93,997	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	37,949	43.00
45.00	04500	NURSING FACILITY	0	45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	567,072	50.00
51.00	05100	RECOVERY ROOM	84,549	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,901	52.00
53.00	05300	ANESTHESIOLOGY	19,834	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,169	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	129,591	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	182,685	60.00
64.00	06400	INTRAVENOUS THERAPY	2,877	64.00
65.00	06500	RESPIRATORY THERAPY	45,595	65.00
66.00	06600	PHYSICAL THERAPY	45,277	66.00
66.01	06601	O/P PHYSICAL THERAPY	78,188	66.01
69.00	06900	ELECTROCARDIOLOGY	11,519	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,388	73.00
74.00	07400	RENAL DIALYSIS	98	74.00
76.00	03020	CLINICAL NUTRITION	550	76.00
76.01	03950	SLEEP LAB	31,392	76.01
76.97	07697	CARDIAC REHABILITATION	58,284	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	17,363	90.00
91.00	09100	EMERGENCY	294,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OPT	0	99.20
99.30	09930	OOT	0	99.30
99.40	09940	OSP	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,039,830	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,365	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	386,052	192.00
194.00	07950	COMMUNITY WELLNESS	87,767	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,548,014	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	76,583				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		76,583			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	469	469	12,310,687		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,391	7,391	1,076,369	-8,032,719	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	12,368	12,368	272,327	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	525	525	0	0	8.00
9.00	00900	HOUSEKEEPING	1,604	1,604	308,784	0	9.00
10.00	01000	DIETARY	814	814	100,879	0	10.00
11.00	01100	CAFETERIA	2,393	2,393	296,781	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	603	603	121,109	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,787	2,787	51,085	0	14.00
15.00	01500	PHARMACY	1,137	1,137	534,580	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	309	309	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	155,359	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,772	11,772	2,175,236	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,729	1,729	156,321	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	409	409	465,676	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,085	10,085	1,336,302	0	50.00
51.00	05100	RECOVERY ROOM	1,599	1,599	119,229	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	562	562	212,178	0	52.00
53.00	05300	ANESTHESIOLOGY	333	333	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,986	6,986	1,158,484	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	117,766	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,637	2,637	790,523	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	640	640	426,374	0	65.00
66.00	06600	PHYSICAL THERAPY	816	816	146,313	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	322,020	0	66.01
69.00	06900	ELECTROCARDIOLOGY	224	224	7,332	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	17,860	0	76.00
76.01	03950	SLEEP LAB	612	612	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,047	1,047	189,849	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	30,805	0	90.00
91.00	09100	EMERGENCY	4,107	4,107	1,571,683	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,958	73,958	12,161,224	-8,032,719	24,106,737	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	672	672	0	0	74,126	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	311	311	0	0	548,315	192.00
194.00	07950	COMMUNITY WELLNESS	1,642	1,642	149,463	0	258,578	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,718,356	1,273,381	2,973,657		8,032,719	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.437826	16.627463	0.241551		0.321466	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,321		309,834	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001488		0.012399	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	56,355			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	525	116,073		8.00
9.00	00900	HOUSEKEEPING	0	1,604	0	54,226	9.00
10.00	01000	DIETARY	0	814	0	814	10.00
11.00	01100	CAFETERIA	0	2,393	0	2,393	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	603	0	603	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,787	0	2,787	0 14.00
15.00	01500	PHARMACY	0	1,137	0	1,137	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	309	0	309	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	11,772	34,010	11,772	1,714 30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,729	733	1,729	83 31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	409	3,964	409	0 43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	10,085	15,137	10,085	0 50.00
51.00	05100	RECOVERY ROOM	0	1,599	0	1,599	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	562	1,460	562	0 52.00
53.00	05300	ANESTHESIOLOGY	0	333	1,345	333	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,986	15,194	6,986	0 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	151	0	0 55.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	2,637	0	2,637	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	640	63	640	0 65.00
66.00	06600	PHYSICAL THERAPY	0	816	21	816	0 66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	3,578	0	0 66.01
69.00	06900	ELECTROCARDIOLOGY	0	224	124	224	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	0 76.00
76.01	03950	SLEEP LAB	0	612	568	612	0 76.01
76.97	07697	CARDIAC REHABILITATION	0	1,047	216	1,047	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	100	0	0 90.00
91.00	09100	EMERGENCY	0	4,107	39,409	4,107	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OPT	0	0	0	0	0 99.20
99.30	09930	OOT	0	0	0	0	0 99.30
99.40	09940	OSP	0	0	0	0	0 99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	53,730	116,073	51,601	1,797 118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	672	0	672	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	311	0	311	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	1,642	0	1,642	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	3,276,830	164,423	929,148	323,899	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	58.146216	1.416548	17.134732	180.244296	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	514,312	26,556	85,601	44,586	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.126289	0.228787	1.578597	24.811352	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	238,564					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,972	0	139,398			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,791	0	0	1,252,114		14.00
15.00	01500	PHARMACY	8,719	0	0	12,634	1,171,069	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,880	0	0	306	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	50,955	0	50,955	102,276	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,456	0	2,456	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,497	0	10,497	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,540	0	30,540	16,907	0	50.00
51.00	05100	RECOVERY ROOM	2,113	0	2,113	2,999	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,868	0	3,868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,449	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,655	0	0	15,026	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,540	0	0	4,693	502,714	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	23,426	0	0	91,447	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	17,988	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,387	0	0	527	0	65.00
66.00	06600	PHYSICAL THERAPY	2,951	0	0	919	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	7,811	0	0	4,244	0	66.01
69.00	06900	ELECTROCARDIOLOGY	166	0	0	53	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	469,260	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	380,450	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,943	668,355	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	449	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	4,167	0	0	452	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,019	0	0	115	0	90.00
91.00	09100	EMERGENCY	38,969	0	38,969	112,714	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,331	0	139,398	1,249,402	1,171,069	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	4,233	0	0	2,712	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	851,622	0	580,019	478,023	1,117,564	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.569784	0.000000	4.160885	0.381773	0.954311	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	130,134	0	36,217	142,220	72,920	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.545489	0.000000	0.259810	0.113584	0.062268	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,126,212					16.00
17.00	01700	SOCIAL SERVICE	0	1,797				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,092,968	1,714	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	236,879	83	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	464,669	0	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,744,318	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	573,942	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,141	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,376,394	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,879,757	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,787,360	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	11,760,438	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,701,406	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,160,058	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	481,366	0	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	1,122,698	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	66,406	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,521,663	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,467,031	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,839,827	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	19,810	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	19,911	0	0	0	0	76.00
76.01	03950	SLEEP LAB	340,235	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	366,951	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	193,847	0	0	0	0	90.00
91.00	09100	EMERGENCY	20,255,137	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
99.30	09930	OOT	0	0	0	0	0	99.30
99.40	09940	OSP	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,126,212	1,797	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	39,667	281,914	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000354	156.880356	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,533	3,873	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000139	2.155259	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM			
			SERVICES-OTHER				
			PRGM COSTS (ASSIGNED TIME)				PRGM (ASSIGNED TIME)
			22.00				23.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
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	
12.00	01200	MAINTENANCE OF PERSONNEL				12.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE				17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00	
20.00	02000	NURSING SCHOOL				20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00	
41.00	04100	SUBPROVIDER - IRF	0	0		41.00	
42.00	04200	SUBPROVIDER	0	0		42.00	
43.00	04300	NURSERY	0	0		43.00	
45.00	04500	NURSING FACILITY	0	0		45.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0		50.00	
51.00	05100	RECOVERY ROOM	0	0		51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00	
53.00	05300	ANESTHESIOLOGY	0	0		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00	
57.00	05700	CT SCAN	0	0		57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00	
60.00	06000	LABORATORY	0	0		60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00	
65.00	06500	RESPIRATORY THERAPY	0	0		65.00	
66.00	06600	PHYSICAL THERAPY	0	0		66.00	
66.01	06601	O/P PHYSICAL THERAPY	0	0		66.01	
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00	
74.00	07400	RENAL DIALYSIS	0	0		74.00	
76.00	03020	CLINICAL NUTRITION	0	0		76.00	
76.01	03950	SLEEP LAB	0	0		76.01	
76.97	07697	CARDIAC REHABILITATION	0	0		76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00	
90.00	09000	CLINIC	0	0		90.00	
91.00	09100	EMERGENCY	0	0		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0		99.10	
99.20	09920	OPT	0	0		99.20	
99.30	09930	OOT	0	0		99.30	
99.40	09940	OSP	0	0		99.40	
101.00	10100	HOME HEALTH AGENCY	0	0		101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0		109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00	
111.00	11100	ISLET ACQUISITION	0	0		111.00	
113.00	11300	INTEREST EXPENSE				113.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet B-1
Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description		INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		22.00			
118.00					
	SUBTOTALS (SUM OF LINES 1 through 117)				118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	COMMUNITY WELLNESS	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 5:58 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,327,184		6,327,184	0
31.00	03100	INTENSIVE CARE UNIT	529,382		529,382	0
41.00	04100	SUBPROVIDER - IRF	0		0	0
42.00	04200	SUBPROVIDER	0		0	0
43.00	04300	NURSERY	914,296		914,296	0
45.00	04500	NURSING FACILITY	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,418,043		4,418,043	0
51.00	05100	RECOVERY ROOM	422,291		422,291	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	402,182		402,182	0
53.00	05300	ANESTHESIOLOGY	137,929		137,929	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,400		3,998,400	0
55.00	05500	RADIOLOGY - THERAPEUTIC	1,534,184		1,534,184	0
57.00	05700	CT SCAN	0		0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	3,035,068		3,035,068	0
64.00	06400	INTRAVENOUS THERAPY	56,713		56,713	0
65.00	06500	RESPIRATORY THERAPY	839,604	0	839,604	0
66.00	06600	PHYSICAL THERAPY	356,169	0	356,169	0
66.01	06601	O/P PHYSICAL THERAPY	669,990	0	669,990	0
69.00	06900	ELECTROCARDIOLOGY	41,653		41,653	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	801,216		801,216	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	648,871		648,871	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,698,343		1,698,343	0
74.00	07400	RENAL DIALYSIS	10,086		10,086	0
76.00	03020	CLINICAL NUTRITION	30,912		30,912	0
76.01	03950	SLEEP LAB	127,543		127,543	0
76.97	07697	CARDIAC REHABILITATION	463,974		463,974	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0
90.00	09000	CLINIC	91,656		91,656	0
91.00	09100	EMERGENCY	4,086,791		4,086,791	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,867,225		1,867,225	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OPT	0		0	0
99.30	09930	OOT	0		0	0
99.40	09940	OSP	0		0	0
101.00	10100	HOME HEALTH AGENCY	0		0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0
111.00	11100	ISLET ACQUISITION	0		0	0
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	33,509,705	0	33,509,705	0
201.00		Less Observation Beds	1,867,225		1,867,225	0
202.00		Total (see instructions)	31,642,480	0	31,642,480	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 5:58 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	6,404,893		6,404,893			30.00
31.00	03100	INTENSIVE CARE UNIT	236,879		236,879			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	464,669		464,669			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,127,265	8,617,053	9,744,318	0.453397	0.000000	50.00
51.00	05100	RECOVERY ROOM	111,522	462,420	573,942	0.735773	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	645,954	7,187	653,141	0.615766	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	444,303	1,932,091	2,376,394	0.058041	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,914,889	24,964,868	26,879,757	0.148751	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,787,360	3,787,360	0.405080	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,711,442	10,048,996	11,760,438	0.258074	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	781,946	1,919,460	2,701,406	0.020994	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	735,923	1,424,135	2,160,058	0.388695	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	390,880	90,486	481,366	0.739913	0.000000	66.00
66.01	06601	O/P PHYSICAL THERAPY	623	1,122,075	1,122,698	0.596768	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	2,496	63,910	66,406	0.627248	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,583,622	3,938,041	5,521,663	0.145104	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,937	2,344,094	2,467,031	0.263017	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,900,482	7,939,345	11,839,827	0.143443	0.000000	73.00
74.00	07400	RENAL DIALYSIS	17,829	1,981	19,810	0.509137	0.000000	74.00
76.00	03020	CLINICAL NUTRITION	189	19,722	19,911	1.552509	0.000000	76.00
76.01	03950	SLEEP LAB	2,080	338,155	340,235	0.374867	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	366,951	366,951	1.264403	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	193,847	193,847	0.472827	0.000000	90.00
91.00	09100	EMERGENCY	704,754	19,550,383	20,255,137	0.201766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,013	1,561,062	1,688,075	1.106127	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
99.30	09930	OOT	0	0	0			99.30
99.40	09940	OSP	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,432,590	90,693,622	112,126,212			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,432,590	90,693,622	112,126,212			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 5:58 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
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	O/P PHYSICAL THERAPY	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	CLINICAL NUTRITION	0.000000		76.00
76.01	03950	SLEEP LAB	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OPT			99.20
99.30	09930	OOT			99.30
99.40	09940	OSP			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 5:58 pm

			Title XIX		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,327,184		6,327,184	0	6,327,184
31.00	03100	INTENSIVE CARE UNIT	529,382		529,382	0	529,382
41.00	04100	SUBPROVIDER - IRF	0		0	0	0
42.00	04200	SUBPROVIDER	0		0	0	0
43.00	04300	NURSERY	914,296		914,296	0	914,296
45.00	04500	NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,418,043		4,418,043	0	4,418,043
51.00	05100	RECOVERY ROOM	422,291		422,291	0	422,291
52.00	05200	DELIVERY ROOM & LABOR ROOM	402,182		402,182	0	402,182
53.00	05300	ANESTHESIOLOGY	137,929		137,929	0	137,929
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,998,400		3,998,400	0	3,998,400
55.00	05500	RADIOLOGY - THERAPEUTIC	1,534,184		1,534,184	0	1,534,184
57.00	05700	CT SCAN	0		0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	3,035,068		3,035,068	0	3,035,068
64.00	06400	INTRAVENOUS THERAPY	56,713		56,713	0	56,713
65.00	06500	RESPIRATORY THERAPY	839,604	0	839,604	0	839,604
66.00	06600	PHYSICAL THERAPY	356,169	0	356,169	0	356,169
66.01	06601	O/P PHYSICAL THERAPY	669,990	0	669,990	0	669,990
69.00	06900	ELECTROCARDIOLOGY	41,653		41,653	0	41,653
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	801,216		801,216	0	801,216
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	648,871		648,871	0	648,871
73.00	07300	DRUGS CHARGED TO PATIENTS	1,698,343		1,698,343	0	1,698,343
74.00	07400	RENAL DIALYSIS	10,086		10,086	0	10,086
76.00	03020	CLINICAL NUTRITION	30,912		30,912	0	30,912
76.01	03950	SLEEP LAB	127,543		127,543	0	127,543
76.97	07697	CARDIAC REHABILITATION	463,974		463,974	0	463,974
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000	CLINIC	91,656		91,656	0	91,656
91.00	09100	EMERGENCY	4,086,791		4,086,791	0	4,086,791
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,867,225		1,867,225	0	1,867,225
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0	0	0
99.20	09920	OPT	0		0	0	0
99.30	09930	OOT	0		0	0	0
99.40	09940	OSP	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0	0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0
111.00	11100	ISLET ACQUISITION	0		0	0	0
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	33,509,705	0	33,509,705	0	33,509,705
201.00		Less Observation Beds	1,867,225		1,867,225		1,867,225
202.00		Total (see instructions)	31,642,480	0	31,642,480	0	31,642,480

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 5:58 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	6,404,893		6,404,893			30.00
31.00	03100	INTENSIVE CARE UNIT	236,879		236,879			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	464,669		464,669			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,127,265	8,617,053	9,744,318	0.453397	0.000000	50.00
51.00	05100	RECOVERY ROOM	111,522	462,420	573,942	0.735773	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	645,954	7,187	653,141	0.615766	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	444,303	1,932,091	2,376,394	0.058041	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,914,889	24,964,868	26,879,757	0.148751	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,787,360	3,787,360	0.405080	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,711,442	10,048,996	11,760,438	0.258074	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	781,946	1,919,460	2,701,406	0.020994	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	735,923	1,424,135	2,160,058	0.388695	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	390,880	90,486	481,366	0.739913	0.000000	66.00
66.01	06601	O/P PHYSICAL THERAPY	623	1,122,075	1,122,698	0.596768	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	2,496	63,910	66,406	0.627248	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,583,622	3,938,041	5,521,663	0.145104	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,937	2,344,094	2,467,031	0.263017	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,900,482	7,939,345	11,839,827	0.143443	0.000000	73.00
74.00	07400	RENAL DIALYSIS	17,829	1,981	19,810	0.509137	0.000000	74.00
76.00	03020	CLINICAL NUTRITION	189	19,722	19,911	1.552509	0.000000	76.00
76.01	03950	SLEEP LAB	2,080	338,155	340,235	0.374867	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	366,951	366,951	1.264403	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	193,847	193,847	0.472827	0.000000	90.00
91.00	09100	EMERGENCY	704,754	19,550,383	20,255,137	0.201766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,013	1,561,062	1,688,075	1.106127	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
99.30	09930	OOT	0	0	0			99.30
99.40	09940	OSP	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,432,590	90,693,622	112,126,212			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,432,590	90,693,622	112,126,212			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 5:58 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
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	O/P PHYSICAL THERAPY	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	CLINICAL NUTRITION	0.000000		76.00
76.01	03950	SLEEP LAB	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OPT			99.20
99.30	09930	OOT			99.30
99.40	09940	OSP			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part II
Date/Time Prepared:
1/27/2020 5:58 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	567,072	9,744,318	0.058195	227,117	13,217	50.00
51.00	05100	RECOVERY ROOM	84,549	573,942	0.147313	24,292	3,579	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,901	653,141	0.053436	0	0	52.00
53.00	05300	ANESTHESIOLOGY	19,834	2,376,394	0.008346	65,264	545	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,169	26,879,757	0.015036	691,044	10,391	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	129,591	3,787,360	0.034217	0	0	55.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	182,685	11,760,438	0.015534	524,703	8,151	60.00
64.00	06400	INTRAVENOUS THERAPY	2,877	2,701,406	0.001065	279,024	297	64.00
65.00	06500	RESPIRATORY THERAPY	45,595	2,160,058	0.021108	317,702	6,706	65.00
66.00	06600	PHYSICAL THERAPY	45,277	481,366	0.094059	155,486	14,625	66.00
66.01	06601	O/P PHYSICAL THERAPY	78,188	1,122,698	0.069643	183	13	66.01
69.00	06900	ELECTROCARDIOLOGY	11,519	66,406	0.173463	1,051	182	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,886	5,521,663	0.010846	514,190	5,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,273	2,467,031	0.019567	37,056	725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,388	11,839,827	0.004509	1,181,878	5,329	73.00
74.00	07400	RENAL DIALYSIS	98	19,810	0.004947	13,867	69	74.00
76.00	03020	CLINICAL NUTRITION	550	19,911	0.027623	0	0	76.00
76.01	03950	SLEEP LAB	31,392	340,235	0.092266	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	58,284	366,951	0.158833	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	17,363	193,847	0.089571	0	0	90.00
91.00	09100	EMERGENCY	294,384	20,255,137	0.014534	13,364	194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	217,795	1,688,075	0.129020	1,336	172	92.00
200.00		Total (lines 50 through 199)	2,387,670	105,019,771		4,047,557	69,772	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1340		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 5:58 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1340		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 5:58 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	0	9,744,318	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	573,942	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	653,141	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,376,394	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	26,879,757	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	3,787,360	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	11,760,438	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	2,701,406	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,160,058	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	481,366	0.000000	66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0	0	0	1,122,698	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	66,406	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,521,663	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,467,031	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,839,827	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	19,810	0.000000	74.00
76.00	03020	CLINICAL NUTRITION	0	0	0	0	19,911	0.000000	76.00
76.01	03950	SLEEP LAB	0	0	0	0	340,235	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	366,951	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	193,847	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	20,255,137	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	1,688,075	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	105,019,771		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part IV
Date/Time Prepared:
1/27/2020 5:58 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	227,117	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	24,292	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	65,264	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	691,044	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	524,703	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	279,024	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	317,702	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	155,486	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.000000	183	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,051	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	514,190	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	37,056	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,181,878	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	13,867	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	0.000000	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	13,364	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,336	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,047,557	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part V
Date/Time Prepared:
1/27/2020 5:58 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	0.453397	0	2,916,769	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.735773	0	100,494	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.615766	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.058041	0	567,781	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148751	0	9,262,552	0	0	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0.405080	0	1,732,359	0	0	55.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.258074	0	3,794,818	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.020994	0	690,291	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.388695	0	637,652	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.739913	0	57,963	0	0	66.00	
66.01	06601	O/P PHYSICAL THERAPY	0.596768	0	358,735	0	0	66.01	
69.00	06900	ELECTROCARDIOLOGY	0.627248	0	26,359	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145104	0	1,169,509	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263017	0	506,309	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.143443	0	2,950,822	6,320	0	73.00	
74.00	07400	RENAL DIALYSIS	0.509137	0	1,981	0	0	74.00	
76.00	03020	CLINICAL NUTRITION	1.552509	0	5,103	0	0	76.00	
76.01	03950	SLEEP LAB	0.374867	0	160,094	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	1.264403	0	164,853	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00	
90.00	09000	CLINIC	0.472827	0	95,843	0	0	90.00	
91.00	09100	EMERGENCY	0.201766	0	5,740,588	1,023	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106127	0	760,065	0	0	92.00	
200.00		Subtotal (see instructions)		0	31,700,940	7,343	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	31,700,940	7,343	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet D Part V Date/Time Prepared: 1/27/2020 5:58 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	1,322,454	0	50.00
51.00	05100	RECOVERY ROOM	73,941	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	32,955	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,377,814	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	701,744	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	979,344	0	60.00
64.00	06400	INTRAVENOUS THERAPY	14,492	0	64.00
65.00	06500	RESPIRATORY THERAPY	247,852	0	65.00
66.00	06600	PHYSICAL THERAPY	42,888	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	214,082	0	66.01
69.00	06900	ELECTROCARDIOLOGY	16,534	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	169,700	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	133,168	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	423,275	907	73.00
74.00	07400	RENAL DIALYSIS	1,009	0	74.00
76.00	03020	CLINICAL NUTRITION	7,922	0	76.00
76.01	03950	SLEEP LAB	60,014	0	76.01
76.97	07697	CARDIAC REHABILITATION	208,441	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	45,317	0	90.00
91.00	09100	EMERGENCY	1,158,255	206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	840,728	0	92.00
200.00		Subtotal (see instructions)	8,071,929	1,113	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,071,929	1,113	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1340

Period:

Worksheet D

Component CCN: 14-Z340

From 09/01/2018
To 08/31/2019Part V
Date/Time Prepared:
1/27/2020 5:58 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	0.453397	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.735773	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.615766	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.058041	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148751	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.405080	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.258074	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.020994	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.388695	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.739913	0	0	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.596768	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.627248	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145104	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263017	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.143443	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.509137	0	0	0	0	74.00
76.00	03020	CLINICAL NUTRITION	1.552509	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0.374867	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.264403	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.472827	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.201766	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106127	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1340

Period:

Worksheet D

Component CCN: 14-Z340

From 09/01/2018
To 08/31/2019Part V
Date/Time Prepared:
1/27/2020 5:58 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
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0					55.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
66.01	06601	O/P PHYSICAL THERAPY	0	0					66.01
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03020	CLINICAL NUTRITION	0	0					76.00
76.01	03950	SLEEP LAB	0	0					76.01
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/27/2020 5:58 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)	2,782	1.00		
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,478	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)	1,657	4.00		
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	304	6.00		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	778	9.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	234	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	145.00	19.00		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	145.00	20.00		
21.00	Total general inpatient routine service cost (see instructions)	6,327,184	21.00		
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00		
26.00	Total swing-bed cost (see instructions)	691,396	26.00		
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,635,788	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)	5,635,788	37.00		
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,274.33	38.00		
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,769,429	39.00		
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00		
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,769,429	41.00		

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	529,382	55	9,625.13	10	96,251		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					873,124		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,738,804		49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge					0.00		55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					532,193		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					532,193		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)						821	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						2,274.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,867,225	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/27/2020 5:58 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	738,009	6,327,184	0.116641	1,867,225	217,795
91.00	Nursing School cost	0	6,327,184	0.000000	1,867,225	0
92.00	Allied health cost	0	6,327,184	0.000000	1,867,225	0
93.00	All other Medical Education	0	6,327,184	0.000000	1,867,225	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/27/2020 5:58 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		1,511,471	30.00
31.00	03100	INTENSIVE CARE UNIT		39,092	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.453397	227,117	50.00
51.00	05100	RECOVERY ROOM	0.735773	24,292	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.615766	0	52.00
53.00	05300	ANESTHESIOLOGY	0.058041	65,264	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148751	691,044	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.405080	0	55.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.258074	524,703	60.00
64.00	06400	INTRAVENOUS THERAPY	0.020994	279,024	64.00
65.00	06500	RESPIRATORY THERAPY	0.388695	317,702	65.00
66.00	06600	PHYSICAL THERAPY	0.739913	155,486	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.596768	183	66.01
69.00	06900	ELECTROCARDIOLOGY	0.627248	1,051	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145104	514,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263017	37,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.143443	1,181,878	73.00
74.00	07400	RENAL DIALYSIS	0.509137	13,867	74.00
76.00	03020	CLINICAL NUTRITION	1.552509	0	76.00
76.01	03950	SLEEP LAB	0.374867	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.264403	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.472827	0	90.00
91.00	09100	EMERGENCY	0.201766	13,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106127	1,336	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,047,557	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		4,047,557	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1340 Component CCN: 14-Z340	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/27/2020 5:58 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
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.453397	6,728	3,050 50.00
51.00	05100	RECOVERY ROOM	0.735773	1,642	1,208 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.615766	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.058041	85,753	4,977 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148751	11,554	1,719 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.405080	0	0 55.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.258074	30,844	7,960 60.00
64.00	06400	INTRAVENOUS THERAPY	0.020994	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.388695	22,116	8,596 65.00
66.00	06600	PHYSICAL THERAPY	0.739913	134,474	99,499 66.00
66.01	06601	O/P PHYSICAL THERAPY	0.596768	312	186 66.01
69.00	06900	ELECTROCARDIOLOGY	0.627248	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145104	30,867	4,479 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263017	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.143443	164,186	23,551 73.00
74.00	07400	RENAL DIALYSIS	0.509137	0	0 74.00
76.00	03020	CLINICAL NUTRITION	1.552509	0	0 76.00
76.01	03950	SLEEP LAB	0.374867	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	1.264403	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.472827	0	0 90.00
91.00	09100	EMERGENCY	0.201766	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106127	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		488,476	155,225 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		488,476	155,225 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1340 Component CCN: 14-Z340	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/27/2020 5:58 pm	
Cost Center Description			Title XIX	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.453397	0	0	50.00
51.00	05100	RECOVERY ROOM	0.735773	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.615766	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.058041	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148751	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.405080	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.258074	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.020994	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.388695	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.739913	0	0	66.00
66.01	06601	O/P PHYSICAL THERAPY	0.596768	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.627248	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145104	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263017	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.143443	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.509137	0	0	74.00
76.00	03020	CLINICAL NUTRITION	1.552509	0	0	76.00
76.01	03950	SLEEP LAB	0.374867	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.264403	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.472827	0	0	90.00
91.00	09100	EMERGENCY	0.201766	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106127	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet E Part B Date/Time Prepared: 1/27/2020 5:58 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,073,042	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)		8,073,042	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)		8,153,772	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)		39,359	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,775,622	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)		2,338,791	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)		2,338,791	30.00
31.00	Primary payer payments		1,838	31.00
32.00	Subtotal (line 30 minus line 31)		2,336,953	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)		882,362	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		573,535	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		627,914	36.00
37.00	Subtotal (see instructions)		2,910,488	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,910,488	40.00
40.01	Sequestration adjustment (see instructions)		58,210	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,448,713	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-596,435	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part I
Date/Time Prepared:
1/27/2020 5:58 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		3,289,597		3,675,520	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		29,799		405,566	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	03/06/2019	54,877	03/06/2019	230,275	3.50
3.51		08/29/2019	33,099	08/29/2019	402,098	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)		-87,976		-632,373	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)		3,231,420		3,448,713	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		760,043		596,435	6.02
7.00	Total Medicare program liability (see instructions)		2,471,377		2,852,278	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: 14-1340

Period:

Worksheet E-1

Component CCN: 14-Z340

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/27/2020 5:58 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		338,466		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	08/29/2019	233,448		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		233,448		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)		571,914		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		102,978		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		674,892		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: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part II
Date/Time Prepared:
1/27/2020 5:58 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: 14-1340

Period:

Worksheet E-2

Component CCN: 14-Z340

From 09/01/2018

To 08/31/2019

Date/Time Prepared:

1/27/2020 5:58 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)		537,515	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)		156,777	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		234	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)		694,292	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		694,292	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)		694,292	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,627	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)		688,665	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		688,665	0	19.00
19.01	Sequestration adjustment (see instructions)		13,773	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		571,914	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)		102,978	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet E-2
		Component CCN: 14-Z340		Date/Time Prepared: 1/27/2020 5:58 pm
		Title XIX	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)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	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)		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		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)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		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)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		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)			16.55
16.99	Demonstration payment adjustment amount before sequestration		0	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	19.02
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		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: 14-1340	Period: From 09/01/2018 To 08/31/2019	Worksheet E-3 Part V Date/Time Prepared: 1/27/2020 5:58 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,738,804	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,738,804	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,766,192	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,766,192	19.00
20.00	Deductibles (exclude professional component)		270,284	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,495,908	22.00
23.00	Coinsurance		2,728	23.00
24.00	Subtotal (line 22 minus line 23)		2,493,180	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		44,050	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		28,633	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,249	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,521,813	28.00
29.00	SEQUESTRATION ADJUSTMENT		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,521,813	30.00
30.01	Sequestration adjustment (see instructions)		50,436	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		3,231,420	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)		-760,043	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: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet G

Date/Time Prepared:
1/27/2020 5:58 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	1,241,489	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	6,572,902	0	0	0	4.00
5.00	Other receivable	175,195	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	835,404	0	0	0	7.00
8.00	Prepaid expenses	68,092	0	0	0	8.00
9.00	Other current assets	1,168,776	0	0	0	9.00
10.00	Due from other funds	-1,604,783	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,457,075	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,794,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	20,547,140	0	0	0	15.00
16.00	Accumulated depreciation	-6,737,463	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,995,010	0	0	0	23.00
24.00	Accumulated depreciation	-3,619,574	0	0	0	24.00
25.00	Minor equipment depreciable	687	0	0	0	25.00
26.00	Accumulated depreciation	-687	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,979,113	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	28,782,581	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	111,594	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,894,175	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,330,363	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	362,377	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,141,160	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,024,550	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,528,087	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,429,987	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,429,987	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,958,074	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	49,372,289				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	49,372,289	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,330,363	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-1

Date/Time Prepared:
1/27/2020 5:58 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		53,747,996		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,786,198				2.00
3.00	Total (sum of line 1 and line 2)		58,534,194		0		3.00
4.00	ROUNDING	2		0		0	4.00
5.00	NET ASSET RELEASE - CAPITAL	15,504		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)		15,506		0		10.00
11.00	Subtotal (line 3 plus line 10)		58,549,700		0		11.00
12.00	IC SETTLEMENT	9,177,411		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)		9,177,411		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,372,289		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	ROUNDING		0				4.00
5.00	NET ASSET RELEASE - CAPITAL		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	IC SETTLEMENT		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: 14-1340

Period:
From 09/01/2018
To 08/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
1/27/2020 5:58 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,404,893		6,404,893	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,404,893		6,404,893	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	236,879		236,879	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	236,879		236,879	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,641,772		6,641,772	17.00
18.00	Ancillary services	13,959,050	69,388,329	83,347,379	18.00
19.00	Outpatient services	831,767	21,305,291	22,137,058	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OPT	0	0	0	24.20
24.30	OOT	0	0	0	24.30
24.40	OSP	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES / OTHER	505,204	4,814,825	5,320,029	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,937,793	95,508,445	117,446,238	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		43,549,904		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	ROUNDING	1			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)		1		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		43,549,903		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1340

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-3

Date/Time Prepared:
1/27/2020 5:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	117,446,238	1.00
2.00	Less contractual allowances and discounts on patients' accounts	69,704,656	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,741,582	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,549,903	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,191,679	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	21,970	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	74,386	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	34,292	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	401,647	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	17,127	24.00
24.01	EXTERNAL GRANTS	-115,284	24.01
24.02	INVESTMENT RETURN REALIZED	99	24.02
24.03	PAYOR INTEREST INCOME	160,281	24.03
24.04	ROUNDING	1	24.04
25.00	Total other income (sum of lines 6-24)	594,519	25.00
26.00	Total (line 5 plus line 25)	4,786,198	26.00
27.00	ROUNDING	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)	4,786,198	29.00