

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: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/26/2019 5:59 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/26/2019	Time: 5:59 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. FRANCIS HOSPITAL (14-1350) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) STEVEN UMLAND

Officer or Administrator of Provider(s)

CFO-HSHS CENTRAL ILLINOIS DIVISION

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	476,184	-246,178	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	53,297	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	529,481	-246,178	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: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 5:59 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1215 FRANCISCAN DRIVE			PO Box:				1.00	
2.00	City: LITCHFIELD			State: IL		Zip Code: 62056		County: MONTGOMERY	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		ST. FRANCIS HOSPITAL	141350	99914	1	12/01/2005	N	0
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		ST. FRANCIS HOSPITAL	142350	99914		05/31/2007	N	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								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019	
21.00	Type of Control (see instructions)						1		
							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		
22.01	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		
22.02	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		
22.03	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	
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		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 5:59 pm	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0	35.00
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							0	37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							N	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	40.00
							V	XVIII	XIX
							1.00	2.00	3.00
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)							N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.							N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							N	56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							N	57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N	58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N	59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
						1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)							N	60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	45,958	15,479	315,568	
		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		148005	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 5:59 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: HOSPITAL SISTERS HEALTH SYSTEM		Contractor's Name: NATIONA GOVERNMENT SERVICES		Contractor's Number: 00131				141.00	
142.00	Street: 4736 LAVERNA ROAD		PO Box:						142.00	
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62794		143.00			
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.									145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								N	146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									0168.00
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)						07/01/2018	06/30/2019	170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 5:59 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/09/2019	Y	10/09/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/26/2019 5:59 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		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		211 N BROADWAY STE 600, ST LOUIS, MO	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 5:59 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	91,776.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	91,776.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	91,776.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,470	103	3,824			1.00
2.00	HMO and other (see instructions)	342	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	448	0	457			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	6			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,918	103	4,287			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		127	374			13.00
14.00	Total (see instructions)	2,918	230	4,661	0.00	222.22	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	222.22	27.00
28.00	Observation Bed Days		35	738			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			18			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	708	41	1,519	1.00
2.00 HMO and other (see instructions)			94	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	708	41	1,519	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/26/2019 5:59 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)		0.270239	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,320,533	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		28,883,271	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,805,386	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)	1,448,400	739,182	2,187,582	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	391,414	739,182	1,130,596	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	391,414	739,182	1,130,596	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,232,090	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,166,838	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,795,135	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		1,436,955	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,016,618	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,147,214	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,147,214	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1350

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

Worksheet A

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		469,441	469,441	1,537,121	2,006,562 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,379,032	2,379,032	-1,536,428	842,604 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	131,122	7,908,794	8,039,916	0	8,039,916 4.00
5.01	00570	ADMITTING	392,998	33,834	426,832	7,340	434,172 5.01
5.02	00540	PATIENT ACCOUNTING	0	779,185	779,185	0	779,185 5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,804,419	6,767,092	8,571,511	-135,448	8,436,063 5.03
6.00	00600	MAINTENANCE & REPAIRS	291,677	30,972	322,649	0	322,649 6.00
7.00	00700	OPERATION OF PLANT	83,411	1,103,881	1,187,292	26,462	1,213,754 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	126,836	126,836 8.00
9.00	00900	HOUSEKEEPING	293,621	247,095	540,716	0	540,716 9.00
10.00	01000	DIETARY	339,949	225,810	565,759	-439,580	126,179 10.00
11.00	01100	CAFETERIA	0	0	0	439,412	439,412 11.00
13.00	01300	NURSING ADMINISTRATION	206,353	26,411	232,764	0	232,764 13.00
15.00	01500	PHARMACY	525,266	2,691,353	3,216,619	-2,426,148	790,471 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	265,927	301,184	567,111	43,999	611,110 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,059,547	472,577	3,532,124	-1,074,385	2,457,739 30.00
43.00	04300	NURSERY	0	0	0	126,046	126,046 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,198,351	1,804,504	3,002,855	-445,665	2,557,190 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	634,040	634,040 52.00
53.00	05300	ANESTHESIOLOGY	0	659,368	659,368	-36,026	623,342 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	930,247	311,380	1,241,627	-24,961	1,216,666 54.00
57.00	05700	CT SCAN	93,317	176,906	270,223	2,465	272,688 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,219	141,948	233,167	4,914	238,081 58.00
60.00	06000	LABORATORY	677,171	968,138	1,645,309	241,669	1,886,978 60.00
65.00	06500	RESPIRATORY THERAPY	359,804	215,024	574,828	19,029	593,857 65.00
66.00	06600	PHYSICAL THERAPY	117,762	921,236	1,038,998	-442	1,038,556 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	119,885	119,885	79,633	199,518 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	456,795	456,795 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,439,941	2,439,941 73.00
76.00	03020	OTHER	0	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	201,927	21,326	223,253	261	223,514 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	294,266	988,812	1,283,078	-2,888	1,280,190 90.00
91.00	09100	EMERGENCY	1,359,857	1,879,956	3,239,813	-65,360	3,174,453 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,718,211	31,645,144	44,363,355	-1,368	44,361,987 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,851	42,851	0	42,851 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	122,487	453,854	576,341	1,368	577,709 192.00
194.00	07950	OTHER NONALLOWABLE	66,431	54,616	121,047	0	121,047 194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,907,129	32,196,465	45,103,594	0	45,103,594 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1350

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

Worksheet A

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,204	2,017,766	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	316,576	1,159,180	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,156,294	4,883,622	4.00
5.01	00570	ADMITTING	-272	433,900	5.01
5.02	00540	PATIENT ACCOUNTING	-52	779,133	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-1,958,890	6,477,173	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	322,649	6.00
7.00	00700	OPERATION OF PLANT	-6,876	1,206,878	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	126,836	8.00
9.00	00900	HOUSEKEEPING	0	540,716	9.00
10.00	01000	DIETARY	0	126,179	10.00
11.00	01100	CAFETERIA	0	439,412	11.00
13.00	01300	NURSING ADMINISTRATION	-2,913	229,851	13.00
15.00	01500	PHARMACY	0	790,471	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-282	610,828	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-168,999	2,288,740	30.00
43.00	04300	NURSERY	0	126,046	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,557,190	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	634,040	52.00
53.00	05300	ANESTHESIOLOGY	-534,239	89,103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-954	1,215,712	54.00
57.00	05700	CT SCAN	0	272,688	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	238,081	58.00
60.00	06000	LABORATORY	-25	1,886,953	60.00
65.00	06500	RESPIRATORY THERAPY	-106,747	487,110	65.00
66.00	06600	PHYSICAL THERAPY	0	1,038,556	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	199,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	456,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,439,941	73.00
76.00	03020	OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	223,514	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-858,456	421,734	90.00
91.00	09100	EMERGENCY	-922,647	2,251,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,389,866	36,972,121	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,851	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	577,709	192.00
194.00	07950	OTHER NONALLOWABLE	0	121,047	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,389,866	37,713,728	200.00

RECLASSIFICATIONS

Provider CCN: 14-1350

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

Worksheet A-6

Date/Time Prepared:
11/26/2019 5:59 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - L&D AND NURSERY SAL & OTHER EXP					
1.00	NURSERY	43.00	118,437	14,788	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	599,611	74,865	2.00
	0		718,048	89,653	
B - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,439,941	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
	0		0	2,439,941	
C - CAFETERIA SALARIES & OTHER COSTS					
1.00	CAFETERIA	11.00	264,031	175,381	1.00
	0		264,031	175,381	
D - LAUNDRY COSTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	126,836	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
	0		0	126,836	
E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	163,212	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	373,375	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	536,587	
F - LAB ADMINISTRATION COSTS					
1.00	LABORATORY	60.00	207,055	34,614	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		207,055	34,614	
G - MOB DEPRECIATION COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	31,112	1.00
	0		0	31,112	
H - SHARED SERVICES COSTS					
1.00	ADMITTING	5.01	7,340	0	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	43,999	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	16,910	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	1,372	0	4.00
5.00	RESPIRATORY THERAPY	65.00	20,927	0	5.00
6.00	CARDIAC REHABILITATION	76.97	261	0	6.00
7.00	EMERGENCY	91.00	12,741	0	7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	93	0	8.00
	0		103,643	0	
I - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,805	1.00
	0		0	31,805	
J - RADIOLOGY MANAGERS COST					
1.00	CT SCAN	57.00	9,101	0	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,904	0	2.00
	0		16,005	0	

RECLASSIFICATIONS

Provider CCN: 14-1350

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

Worksheet A-6

Date/Time Prepared:
11/26/2019 5:59 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	0 - SEGREGATE DIRECT COSTS				1.00
	IMPL. DEV. CHARGED TO	72.00	0	83,420	
	PATIENTS _____	_____	_____	_____	
	0		0	83,420	
1.00	P - DEPRECIATION EXPENSE RECLASS				1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	1,505,316	
	0		0	1,505,316	
1.00	Q - MOB UTILITIES				1.00
	OPERATION OF PLANT _____	7.00	0	26,462	
	TOTALS		0	26,462	
500.00	Grand Total: Increases		1,308,782	5,081,127	500.00

RECLASSIFICATIONS

Provider CCN: 14-1350

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

Worksheet A-6

Date/Time Prepared:
11/26/2019 5:59 pm

	Decreases						11/26/2019 5:59 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - L&D AND NURSERY SAL & OTHER EXP						
1.00	ADULTS & PEDIATRICS	30.00	718,048	89,653	0		1.00
2.00		0.00	0	0	0		2.00
	0		718,048	89,653			
	B - DRUG COSTS						
1.00	DIETARY	10.00	0	168	0		1.00
2.00	PHARMACY	15.00	0	2,424,900	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	806	0		3.00
4.00	OPERATING ROOM	50.00	0	2,264	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	5,629	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	371	0		6.00
7.00	CT SCAN	57.00	0	2,867	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	216	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	126	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	159	0		10.00
11.00	CLINIC	90.00	0	556	0		11.00
12.00	EMERGENCY	91.00	0	1,879	0		12.00
	0		0	2,439,941			
	C - CAFETERIA SALARIES & OTHER COSTS						
1.00	DIETARY	10.00	264,031	175,381	0		1.00
	0		264,031	175,381			
	D - LAUNDRY COSTS						
1.00	PHARMACY	15.00	0	1,248	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	52,362	0		2.00
3.00	NURSERY	43.00	0	2,284	0		3.00
4.00	OPERATING ROOM	50.00	0	15,989	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,561	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,957	0		6.00
7.00	CT SCAN	57.00	0	3,769	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,774	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,898	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	316	0		10.00
11.00	CLINIC	90.00	0	2,332	0		11.00
12.00	EMERGENCY	91.00	0	19,971	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,375	0		13.00
	0		0	126,836			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	5,440	0		1.00
2.00	NURSERY	43.00	0	4,895	0		2.00
3.00	OPERATING ROOM	50.00	0	427,412	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	24,782	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	30,397	0		5.00
6.00	EMERGENCY	91.00	0	43,661	0		6.00
	0		0	536,587			
	F - LAB ADMINISTRATION COSTS						
1.00	ADULTS & PEDIATRICS	30.00	197,787	27,199	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,846	247	0		2.00
3.00	EMERGENCY	91.00	5,422	7,168	0		3.00
	0		207,055	34,614			
	G - MOB DEPRECIATION COSTS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	31,112	9		1.00
	0		0	31,112			
	H - SHARED SERVICES COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.03	103,643	0	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
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		103,643	0			
	I - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.03	0	31,805	12		1.00
	0		0	31,805			
	J - RADIOLOGY MANAGERS COST						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	16,005	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		16,005	0			

RECLASSIFICATIONS

Provider CCN: 14-1350

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

Worksheet A-6

Date/Time Prepared:
11/26/2019 5:59 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	O - SEGREGATE DIRECT COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	83,420	0	1.00
	0		0	83,420		
	P - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,505,316	9	1.00
	0		0	1,505,316		
	Q - MOB UTILITIES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	26,462	0	1.00
	TOTALS		0	26,462		
500.00	Grand Total: Decreases		1,308,782	5,081,127		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	410,028	52,192	0	52,192	0	1.00	
2.00	Land Improvements	1,922,999	0	0	0	11,252	2.00	
3.00	Buildings and Fixtures	11,926,818	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	26,990,707	2,088,071	0	2,088,071	0	5.00	
6.00	Movable Equipment	18,636,909	1,332,320	0	1,332,320	505,366	6.00	
7.00	HIT designated Assets	5,136,661	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	65,024,122	3,472,583	0	3,472,583	516,618	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	65,024,122	3,472,583	0	3,472,583	516,618	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	462,220	0				1.00	
2.00	Land Improvements	1,911,747	0				2.00	
3.00	Buildings and Fixtures	11,926,818	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	29,078,778	0				5.00	
6.00	Movable Equipment	19,463,863	0				6.00	
7.00	HIT designated Assets	5,136,661	0				7.00	
8.00	Subtotal (sum of lines 1-7)	67,980,087	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	67,980,087	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	437,636	0	0	31,805	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,379,032	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,816,668	0	0	31,805	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	469,441				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,379,032				2.00
3.00	Total (sum of lines 1-2)	0	2,848,473				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,379,563	0	43,379,563	0.638122	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,600,524	0	24,600,524	0.361878	0	2.00
3.00	Total (sum of lines 1-2)	67,980,087	0	67,980,087	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,954,156	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,159,180	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,113,336	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	63,610	0	0	2,017,766	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,159,180	2.00
3.00	Total (sum of lines 1-2)	0	63,610	0	0	3,176,946	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1350

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

Worksheet A-8

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,876	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,589,488			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,083,968			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-652,581	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MARKETING SALARY	A	-97,204	ADMINISTRATIVE & GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1350

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

Worksheet A-8

Date/Time Prepared:
11/26/2019 5:59 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 MARKETING BENEFITS	B	-42,629	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02 MARKETING OTHER	B	-257,055	ADMINISTRATIVE & GENERAL	5.03	0	33.02
33.03 MISC INCOME	B	-1,175,519	ADMINISTRATIVE & GENERAL	5.03	0	33.03
33.04 BANK CHARGES	A	24,166	ADMINISTRATIVE & GENERAL	5.03	0	33.04
33.05 LAB MISC INCOME	B	-25	LABORATORY	60.00	0	33.05
33.06 RADIOLOGY MISC REVENUE	B	-954	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07 HIS MISC INCOME	B	-282	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08 ALCOHOL BEVERAGE COST	A	-1,679	ADMINISTRATIVE & GENERAL	5.03	0	33.08
33.09 ALCOHOL BEVERAGE COST	A	-19	NURSING ADMINISTRATION	13.00	0	33.09
33.10 ADVERTISING COST	A	-272	ADMINISTRATIVE & GENERAL	5.03	0	33.10
33.11 ADVERTISING COST	A	-60	ADMINISTRATIVE & GENERAL	5.03	0	33.11
33.12 DEFINED PENSION ADJUSTMENT	A	-2,194,485	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 FUND DEVELOPMENT - SALARY	A	-109,363	ADMINISTRATIVE & GENERAL	5.03	0	33.13
33.14 FUND DEVELOPMENT - OTHER	B	56,375	ADMINISTRATIVE & GENERAL	5.03	0	33.14
33.15 SELF-INS TO HOSP/EMP CLIMS	A	-905,819	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16 PHYSICIAN RECRUITMENT	A	14,904	ADMINISTRATIVE & GENERAL	5.03	0	33.16
33.17 MEDICAID TAX ASSESSMENT	A	-1,363,869	ADMINISTRATIVE & GENERAL	5.03	0	33.17
33.18 LOBBYING EXPENSES	A	-14,477	ADMINISTRATIVE & GENERAL	5.03	0	33.18
33.19 MEALS TO NON-PROVIDERS	A	-54,664	ADMINISTRATIVE & GENERAL	5.03	0	33.19
33.20 CHARITABLE CONTRIBUTIONS	A	-550	ADMINISTRATIVE & GENERAL	5.03	0	33.20
33.21 NON-PATIENT TRAVEL	A	-272	ADMITTING	5.01	0	33.21
33.22 NON-PATIENT TRAVEL	A	-52	PATIENT ACCOUNTING	5.02	0	33.22
33.23 NON-PATIENT TRAVEL	A	-10,394	ADMINISTRATIVE & GENERAL	5.03	0	33.23
33.24 NON-PATIENT TRAVEL	A	-2,894	NURSING ADMINISTRATION	13.00	0	33.24
33.25 NON-PATIENT TRAVEL	A	-529	ADULTS & PEDIATRICS	30.00	0	33.25
33.26 NON-PATIENT TRAVEL	A	-448	CLINIC	90.00	0	33.26
33.27 FUND DEVELOPMENT - BENEFITS	A	-66,558	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28 ASSET RELIFING-BUILDING	A	11,204	CAP REL COSTS-BLDG & FIXT	1.00	9	33.28
33.29 ASSET RELIFING-EQUIPMENT	A	969,157	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.29
33.30 ORTHO CLINIC CABLE EXPENSE	A	-623	CLINIC	90.00	0	33.30
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,389,866				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: 14-1350

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2019 5:59 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF-INS PREMIUMS	3,164,846	3,111,649	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVCS	20,569	20,569	2.00
3.00	5.03	ADMINISTRATIVE & GENERAL	CONTRACT SERVICES - HSHS	4,067,108	3,036,337	3.00
3.01	5.03	ADMINISTRATIVE & GENERAL	RELATED PARTY SVCS	760,097	760,097	3.01
3.02	5.01	ADMITTING	RELATED PARTY SVCS	13,517	13,517	3.02
3.03	5.02	PATIENT ACCOUNTING	RELATED PARTY SVCS	206,125	206,125	3.03
3.04	7.00	OPERATION OF PLANT	RELATED PARTY SVCS	110	110	3.04
3.05	9.00	HOUSEKEEPING	RELATED PARTY SVCS	225	225	3.05
3.06	10.00	DIETARY	RELATED PARTY SVCS	1,150	1,150	3.06
3.07	13.00	NURSING ADMINISTRATION	RELATED PARTY SVCS	2,448	2,448	3.07
3.08	15.00	PHARMACY	RELATED PARTY SVCS	15,139	15,139	3.08
3.09	16.00	MEDICAL RECORDS & LIBRARY	RELATED PARTY SVCS	79,749	79,749	3.09
3.10	30.00	ADULTS & PEDIATRICS	RELATED PARTY SVCS	201,199	201,199	3.10
3.11	50.00	OPERATING ROOM	RELATED PARTY SVCS	1,609	1,609	3.11
3.12	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SVCS	191,874	191,874	3.12
3.13	60.00	LABORATORY	RELATED PARTY SVCS	228,980	228,980	3.13
3.14	65.00	RESPIRATORY THERAPY	RELATED PARTY SVCS	102,192	102,192	3.14
3.15	76.97	CARDIAC REHABILITATION	RELATED PARTY SVCS	2,412	2,412	3.15
3.16	90.00	CLINIC	RELATED PARTY SVCS	94,425	94,425	3.16
3.17	91.00	EMERGENCY	RELATED PARTY SVCS	13,117	13,117	3.17
3.18	190.00	GIFT, FLOWER, COFFEE SHOP &	RELATED PARTY SVCS	8,000	8,000	3.18
3.19	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY SVCS	349	349	3.19
3.20	194.00	OTHER NONALLOWABLE	RELATED PARTY SVCS	254	254	3.20
3.21	0.00			0	0	3.21
3.22	0.00			0	0	3.22
3.23	0.00			0	0	3.23
3.24	0.00			0	0	3.24
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,175,494	8,091,526	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	HSHS	100.00	HSHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1350

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2019 5:59 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	53,197	0		1.00
2.00	0	0		2.00
3.00	1,030,771	0		3.00
3.01	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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
3.21	0	0		3.21
3.22	0	0		3.22
3.23	0	0		3.23
3.24	0	0		3.24
4.00	0	0		4.00
5.00	1,083,968			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	CORPORATE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1350

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2019 5:59 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	53.00	ANESTHESIOLOGY	534,239	534,239	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	106,747	106,747	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	32,000	0	32,000	0	0	4.00
5.00	91.00	EMERGENCY	1,729,117	922,647	806,470	0	0	5.00
6.00	90.00	CLINIC	857,385	857,385	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	168,470	168,470	0	0	0	7.00
8.00	5.03	ADMINISTRATIVE & GENERAL	89,335	0	89,335	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,517,293	2,589,488	927,805		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	534,239		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	106,747		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	922,647		5.00
6.00	90.00	CLINIC	0	0	0	857,385		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	168,470		7.00
8.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,589,488		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2019 5:59 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					7.47	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	3,577.50	1,845.75	5,469.00	119.00	0.00	9.00
10.00	AHSEA (see instructions)	112.84	83.59	62.69	41.79	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.80	41.80	31.35			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					403,685	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					154,286	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					342,852	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					900,823	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					4,973	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					905,796	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					905,796	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2019 5:59 pm		
		Physical Therapy				Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.59	62.69	41.79	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						905,796	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						905,796	63.00
64.00	Total cost of outside supplier services (from your records)						825,895	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2019 5:59 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					216	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					29	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					7.47	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	48.00	991.75	69.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	106.97	79.23	59.43	39.62	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.62	39.62	29.72			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					5,135	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					78,576	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					4,101	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					87,812	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					87,812	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					87,812	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					8,558	24.00
25.00	Assistants (line 4 times column 3, line 11)					862	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,420	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,830	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,250	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,250	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2019 5:59 pm		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.23	59.43	39.62	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						87,812	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						11,250	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						99,062	63.00
64.00	Total cost of outside supplier services (from your records)						48,703	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						9,420	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,830	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						11,250	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,830	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						1,830	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2019 5:59 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						107	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						7.47	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	245.46	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	102.79	76.14	57.10	38.07	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.07	38.07	28.55			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						18,689	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						18,689	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						18,689	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						76.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						59,389	22.00
23.00	Total salary equivalency (see instructions)						59,389	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						4,073	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						4,073	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						799	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						4,872	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						4,872	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2019 5:59 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.14	57.10	38.07	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						59,389	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						4,872	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						64,261	63.00
64.00	Total cost of outside supplier services (from your records)						20,268	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						4,073	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						799	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						4,872	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						799	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						799	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1350

Period:
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To 06/30/2019Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,017,766	2,017,766			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,159,180		1,159,180		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,883,622	5,451	1,447	4,890,520	4.00
5.01	00570	ADMITTING	433,900	36,051	2,229	153,245	5.01
5.02	00540	PATIENT ACCOUNTING	779,133	2,798	0	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	6,477,173	235,239	0	651,038	5.03
6.00	00600	MAINTENANCE & REPAIRS	322,649	0	0	111,651	6.00
7.00	00700	OPERATION OF PLANT	1,206,878	454,365	0	31,929	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	126,836	0	0	0	8.00
9.00	00900	HOUSEKEEPING	540,716	40,121	277	112,395	9.00
10.00	01000	DIETARY	126,179	109,364	9,872	29,061	10.00
11.00	01100	CAFETERIA	439,412	35,760	0	101,068	11.00
13.00	01300	NURSING ADMINISTRATION	229,851	6,517	15,921	78,990	13.00
15.00	01500	PHARMACY	790,471	22,798	29,799	201,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	610,828	0	90	118,636	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,288,740	232,319	295,301	827,068	30.00
43.00	04300	NURSERY	126,046	10,660	0	45,336	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,557,190	178,243	190,158	458,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	634,040	52,126	0	228,052	52.00
53.00	05300	ANESTHESIOLOGY	89,103	5,718	12,304	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,215,712	109,800	182,337	350,487	54.00
57.00	05700	CT SCAN	272,688	6,457	9,638	39,204	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	238,081	21,429	326,020	37,560	58.00
60.00	06000	LABORATORY	1,886,953	57,735	24,974	338,472	60.00
65.00	06500	RESPIRATORY THERAPY	487,110	39,297	21,123	145,740	65.00
66.00	06600	PHYSICAL THERAPY	1,038,556	3,368	4,311	45,078	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	199,518	30,624	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	456,795	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,439,941	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	223,514	17,105	0	77,395	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	421,734	0	3,218	112,642	90.00
91.00	09100	EMERGENCY	2,251,806	96,572	30,052	523,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,972,121	1,809,917	1,159,071	4,818,169	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,851	11,375	109	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	577,709	196,474	0	46,922	192.00
194.00	07950	OTHER NONALLOWABLE	121,047	0	0	25,429	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,713,728	2,017,766	1,159,180	4,890,520	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1350

Period:
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To 06/30/2019Worksheet B
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Cost Center Description			PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5A.02	5.03	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING	781,931					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	7,363,450	7,363,450			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	434,300	105,368	539,668		6.00
7.00	00700	OPERATION OF PLANT	0	1,693,172	410,791	141,066	2,245,029	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	126,836	30,772	0	0	8.00
9.00	00900	HOUSEKEEPING	0	693,509	168,256	12,456	70,158	9.00
10.00	01000	DIETARY	0	274,476	66,592	33,954	191,239	10.00
11.00	01100	CAFETERIA	0	576,240	139,805	11,102	62,532	11.00
13.00	01300	NURSING ADMINISTRATION	0	331,279	80,374	2,023	11,396	13.00
15.00	01500	PHARMACY	0	1,044,134	253,324	7,078	39,866	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	729,554	177,001	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,997	3,710,020	900,097	72,128	406,248	30.00
43.00	04300	NURSERY	1,647	185,006	44,885	3,310	18,641	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,287	3,480,220	844,357	55,339	311,685	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,325	929,202	225,439	16,184	91,150	52.00
53.00	05300	ANESTHESIOLOGY	44,678	187,542	45,501	1,775	9,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,717	2,021,620	490,477	34,090	192,002	54.00
57.00	05700	CT SCAN	110,944	527,614	128,008	2,005	11,290	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	40,017	695,118	168,647	6,653	37,473	58.00
60.00	06000	LABORATORY	96,078	2,481,068	601,947	17,925	100,958	60.00
65.00	06500	RESPIRATORY THERAPY	13,606	717,760	174,140	12,201	68,717	65.00
66.00	06600	PHYSICAL THERAPY	40,142	1,163,566	282,300	1,046	5,889	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,005	264,350	64,136	9,508	53,550	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,099	485,772	117,856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,602	2,610,218	633,281	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	17,873	350,184	84,960	5,311	29,910	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,065	575,509	139,628	0	0	90.00
91.00	09100	EMERGENCY	76,849	3,040,093	737,575	29,983	168,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	781,931	36,691,812	7,115,517	475,137	1,881,572	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,335	13,183	3,532	19,891	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	821,105	199,213	60,999	343,566	192.00
194.00	07950	OTHER NONALLOWABLE	0	146,476	35,537	0	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)	781,931	37,713,728	7,363,450	539,668	2,245,029	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	157,608					8.00
9.00	00900	HOUSEKEEPING	0	944,379				9.00
10.00	01000	DIETARY	0	0	566,261			10.00
11.00	01100	CAFETERIA	0	0	0	789,679		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,806	0	7,177	437,055	13.00
15.00	01500	PHARMACY	0	8,884	0	27,220	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	35,063	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	65,974	205,191	566,261	202,020	201,360	30.00
43.00	04300	NURSERY	2,851	9,409	0	5,024	5,007	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,021	137,225	0	90,527	90,231	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,433	47,613	0	42,649	42,510	52.00
53.00	05300	ANESTHESIOLOGY	0	7,956	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,668	72,812	0	77,763	0	54.00
57.00	05700	CT SCAN	4,717	6,785	0	7,894	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,234	0	0	5,946	0	58.00
60.00	06000	LABORATORY	0	49,268	0	58,233	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,375	22,494	0	33,781	0	65.00
66.00	06600	PHYSICAL THERAPY	372	10,338	0	36,242	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,117	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	19,344	0	11,841	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,852	29,359	0	26,656	0	90.00
91.00	09100	EMERGENCY	24,826	132,984	0	98,268	97,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,323	772,585	566,261	766,304	437,055	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,958	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,285	167,836	0	18,249	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	5,126	0	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)	157,608	944,379	566,261	789,679	437,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,380,506					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	941,618				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	235,890	0	6,565,189	0	30.00
43.00	04300	NURSERY	0	12,931	0	287,064	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	130,832	0	5,160,437	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	65,044	0	1,474,224	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	252,772	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,964	0	3,001,396	0	54.00
57.00	05700	CT SCAN	0	11,182	0	699,495	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,713	0	926,784	0	58.00
60.00	06000	LABORATORY	0	96,537	0	3,405,936	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	41,567	0	1,073,035	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,857	0	1,512,610	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	399,661	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	603,628	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,380,506	0	0	4,624,005	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	22,074	0	523,624	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	32,127	0	806,131	0	90.00
91.00	09100	EMERGENCY	0	149,264	0	4,479,810	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,380,506	920,982	0	35,795,801	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	94,899	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,383	0	1,628,636	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	7,253	0	194,392	0	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)	1,380,506	941,618	0	37,713,728	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00540	PATIENT ACCOUNTING		5.02
5.03	00550	ADMINISTRATIVE & GENERAL		5.03
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	6,565,189	30.00
43.00	04300	NURSERY	287,064	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,160,437	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,474,224	52.00
53.00	05300	ANESTHESIOLOGY	252,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,001,396	54.00
57.00	05700	CT SCAN	699,495	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	926,784	58.00
60.00	06000	LABORATORY	3,405,936	60.00
65.00	06500	RESPIRATORY THERAPY	1,073,035	65.00
66.00	06600	PHYSICAL THERAPY	1,512,610	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	399,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	603,628	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,624,005	73.00
76.00	03020	OTHER	0	76.00
76.97	07697	CARDIAC REHABILITATION	523,624	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	806,131	90.00
91.00	09100	EMERGENCY	4,479,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		35,795,801	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	94,899	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,628,636	192.00
194.00	07950	OTHER NONALLOWABLE	194,392	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,713,728	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	581	5,451	1,447	7,479	4.00
5.01	00570	ADMITTING	2,559	36,051	2,229	40,839	5.01
5.02	00540	PATIENT ACCOUNTING	0	2,798	0	2,798	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,225,846	235,239	0	1,461,085	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	9,439	454,365	0	463,804	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	400	40,121	277	40,798	9.00
10.00	01000	DIETARY	400	109,364	9,872	119,636	10.00
11.00	01100	CAFETERIA	0	35,760	0	35,760	11.00
13.00	01300	NURSING ADMINISTRATION	200	6,517	15,921	22,638	13.00
15.00	01500	PHARMACY	91,813	22,798	29,799	144,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,143	0	90	5,233	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,522	232,319	295,301	535,142	30.00
43.00	04300	NURSERY	0	10,660	0	10,660	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,590	178,243	190,158	402,991	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,126	0	52,126	52.00
53.00	05300	ANESTHESIOLOGY	1,948	5,718	12,304	19,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660	109,800	182,337	293,797	54.00
57.00	05700	CT SCAN	0	6,457	9,638	16,095	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,429	326,020	347,449	58.00
60.00	06000	LABORATORY	34,324	57,735	24,974	117,033	60.00
65.00	06500	RESPIRATORY THERAPY	20,064	39,297	21,123	80,484	65.00
66.00	06600	PHYSICAL THERAPY	781	3,368	4,311	8,460	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,255	30,624	0	38,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	981	17,105	0	18,086	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	3,218	3,218	90.00
91.00	09100	EMERGENCY	3,068	96,572	30,052	129,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,449,574	1,809,917	1,159,071	4,418,562	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,375	109	11,484	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,911	196,474	0	205,385	192.00
194.00	07950	OTHER NONALLOWABLE	7,800	0	0	7,800	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,466,285	2,017,766	1,159,180	4,643,231	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

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Cost Center Description			ADMITTING	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5.02	5.03	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	41,073					5.01
5.02	00540	PATIENT ACCOUNTING	0	2,798				5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	0	1,462,080			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	20,922	21,093		6.00
7.00	00700	OPERATION OF PLANT	0	0	81,567	5,513	550,933	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	6,110	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	33,409	487	17,217	9.00
10.00	01000	DIETARY	0	0	13,223	1,327	46,930	10.00
11.00	01100	CAFETERIA	0	0	27,760	434	15,345	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	15,959	79	2,797	13.00
15.00	01500	PHARMACY	0	0	50,300	277	9,783	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	35,146	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,943	132	178,710	2,819	99,694	30.00
43.00	04300	NURSERY	86	6	8,912	129	4,575	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,798	190	167,656	2,163	76,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	437	30	44,763	633	22,368	52.00
53.00	05300	ANESTHESIOLOGY	2,346	159	9,035	69	2,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,764	323	97,390	1,332	47,118	54.00
57.00	05700	CT SCAN	5,836	409	25,417	78	2,771	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,102	142	33,487	260	9,196	58.00
60.00	06000	LABORATORY	5,046	342	119,523	701	24,775	60.00
65.00	06500	RESPIRATORY THERAPY	715	48	34,577	477	16,863	65.00
66.00	06600	PHYSICAL THERAPY	2,108	143	56,054	41	1,445	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	998	68	12,735	372	13,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	845	57	23,402	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,968	337	125,745	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	939	64	16,870	208	7,340	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,106	75	27,725	0	0	90.00
91.00	09100	EMERGENCY	4,036	273	146,453	1,172	41,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,073	2,798	1,412,850	18,571	461,741	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,618	138	4,881	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	39,556	2,384	84,311	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	7,056	0	0	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)	41,073	2,798	1,462,080	21,093	550,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

Period:
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To 06/30/2019Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,110					8.00
9.00	00900	HOUSEKEEPING	0	92,083				9.00
10.00	01000	DIETARY	0	0	181,160			10.00
11.00	01100	CAFETERIA	0	0	0	79,453		11.00
13.00	01300	NURSING ADMINISTRATION	0	469	0	722	42,785	13.00
15.00	01500	PHARMACY	0	866	0	2,739	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,528	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,557	20,007	181,160	20,328	19,713	30.00
43.00	04300	NURSERY	111	917	0	505	490	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	776	13,380	0	9,108	8,833	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560	4,643	0	4,291	4,161	52.00
53.00	05300	ANESTHESIOLOGY	0	776	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491	7,100	0	7,824	0	54.00
57.00	05700	CT SCAN	183	662	0	794	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	87	0	0	598	0	58.00
60.00	06000	LABORATORY	0	4,804	0	5,859	0	60.00
65.00	06500	RESPIRATORY THERAPY	92	2,193	0	3,399	0	65.00
66.00	06600	PHYSICAL THERAPY	14	1,008	0	3,646	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	791	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,886	0	1,191	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	111	2,863	0	2,682	0	90.00
91.00	09100	EMERGENCY	962	12,967	0	9,887	9,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,944	75,332	181,160	77,101	42,785	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	386	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	166	16,365	0	1,836	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	516	0	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)	6,110	92,083	181,160	79,453	42,785	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	208,682					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,088				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	11,042	0	1,074,516	0	30.00
43.00	04300	NURSERY	0	605	0	27,065	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,126	0	691,210	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,046	0	137,407	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	34,809	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,681	0	465,356	0	54.00
57.00	05700	CT SCAN	0	524	0	52,829	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	502	0	393,880	0	58.00
60.00	06000	LABORATORY	0	4,520	0	283,120	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,946	0	141,017	0	65.00
66.00	06600	PHYSICAL THERAPY	0	602	0	73,590	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	66,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,304	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,682	0	0	339,732	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,034	0	47,736	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,504	0	39,456	0	90.00
91.00	09100	EMERGENCY	0	6,989	0	364,260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	208,682	43,121	0	4,257,271	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	19,507	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	627	0	350,702	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	340	0	15,751	0	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)	208,682	44,088	0	4,643,231	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00570	ADMITTING	5.01
5.02	00540	PATIENT ACCOUNTING	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	5.03
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	OTHER	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONALLOWABLE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1350

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	166,567					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,257,877				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	450	1,570	12,776,007			4.00
5.01	00570	ADMITTING	2,976	2,419	400,338	132,459,964		5.01
5.02	00540	PATIENT ACCOUNTING	231	0	0	0	132,459,964	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	19,419	0	1,700,776	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	291,677	0	0	6.00
7.00	00700	OPERATION OF PLANT	37,508	0	83,411	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,312	301	293,621	0	0	9.00
10.00	01000	DIETARY	9,028	10,712	75,918	0	0	10.00
11.00	01100	CAFETERIA	2,952	0	264,031	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	538	17,277	206,353	0	0	13.00
15.00	01500	PHARMACY	1,882	32,336	525,266	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	98	309,926	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,178	320,444	2,160,622	6,267,494	6,267,494	30.00
43.00	04300	NURSERY	880	0	118,437	278,998	278,998	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,714	206,349	1,198,351	9,027,080	9,027,080	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,303	0	595,765	1,410,278	1,410,278	52.00
53.00	05300	ANESTHESIOLOGY	472	13,352	0	7,568,622	7,568,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,064	197,862	915,614	15,367,869	15,367,869	54.00
57.00	05700	CT SCAN	533	10,459	102,418	18,791,431	18,791,431	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,769	353,777	98,123	6,779,073	6,779,073	58.00
60.00	06000	LABORATORY	4,766	27,100	884,226	16,276,127	16,276,127	60.00
65.00	06500	RESPIRATORY THERAPY	3,244	22,922	380,731	2,304,902	2,304,902	65.00
66.00	06600	PHYSICAL THERAPY	278	4,678	117,762	6,800,333	6,800,333	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,528	0	0	3,219,582	3,219,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,727,190	2,727,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,026,066	16,026,066	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,412	0	202,188	3,027,811	3,027,811	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,492	294,266	3,568,457	3,568,457	90.00
91.00	09100	EMERGENCY	7,972	32,611	1,367,176	13,018,651	13,018,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	149,409	1,257,759	12,586,996	132,459,964	132,459,964	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	939	118	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,219	0	122,580	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	66,431	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)	2,017,766	1,159,180	4,890,520	625,425	781,931	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.113840	0.921537	0.382789	0.004722	0.005903	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,479	41,073	2,798	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000585	0.000310	0.000021	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: 14-1350

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A.03	5.03	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00540	PATIENT ACCOUNTING					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-7,363,450	30,350,278			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	434,300	143,491		6.00
7.00	00700	OPERATION OF PLANT	0	1,693,172	37,508	105,983	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	126,836	0	0	8.00
9.00	00900	HOUSEKEEPING	0	693,509	3,312	3,312	9.00
10.00	01000	DIETARY	0	274,476	9,028	9,028	10.00
11.00	01100	CAFETERIA	0	576,240	2,952	2,952	11.00
13.00	01300	NURSING ADMINISTRATION	0	331,279	538	538	13.00
15.00	01500	PHARMACY	0	1,044,134	1,882	1,882	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	729,554	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,710,020	19,178	19,178	30.00
43.00	04300	NURSERY	0	185,006	880	880	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,480,220	14,714	14,714	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	929,202	4,303	4,303	52.00
53.00	05300	ANESTHESIOLOGY	0	187,542	472	472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,021,620	9,064	9,064	54.00
57.00	05700	CT SCAN	0	527,614	533	533	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	695,118	1,769	1,769	58.00
60.00	06000	LABORATORY	0	2,481,068	4,766	4,766	60.00
65.00	06500	RESPIRATORY THERAPY	0	717,760	3,244	3,244	65.00
66.00	06600	PHYSICAL THERAPY	0	1,163,566	278	278	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	264,350	2,528	2,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	485,772	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,610,218	0	0	73.00
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	350,184	1,412	1,412	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	575,509	0	0	90.00
91.00	09100	EMERGENCY	0	3,040,093	7,972	7,972	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,363,450	29,328,362	126,333	88,825	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,335	939	939	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	821,105	16,219	16,219	192.00
194.00	07950	OTHER NONALLOWABLE	0	146,476	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)		7,363,450	539,668	2,245,029	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.242616	3.760988	21.182916	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,462,080	21,093	550,933	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.048174	0.146999	5.198315	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: 14-1350

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description			HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
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	23,385					9.00
10.00	01000	DIETARY	0	24,890				10.00
11.00	01100	CAFETERIA	0	0	15,405			11.00
13.00	01300	NURSING ADMINISTRATION	119	0	140	8,554		13.00
15.00	01500	PHARMACY	220	0	531	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	684	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,081	24,890	3,941	3,941	0	30.00
43.00	04300	NURSERY	233	0	98	98	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,398	0	1,766	1,766	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,179	0	832	832	0	52.00
53.00	05300	ANESTHESIOLOGY	197	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,803	0	1,517	0	0	54.00
57.00	05700	CT SCAN	168	0	154	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	116	0	0	58.00
60.00	06000	LABORATORY	1,220	0	1,136	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	557	0	659	0	0	65.00
66.00	06600	PHYSICAL THERAPY	256	0	707	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	201	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	100	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	479	0	231	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	727	0	520	0	0	90.00
91.00	09100	EMERGENCY	3,293	0	1,917	1,917	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,131	24,890	14,949	8,554	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	98	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,156	0	356	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	100	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)	944,379	566,261	789,679	437,055	1,380,506	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.383964	22.750542	51.261214	51.093640	13,805.060000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,083	181,160	79,453	42,785	208,682	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.937695	7.278425	5.157611	5.001754	2,086.820000	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: 14-1350

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS SALARIES)	SOCIAL SERVICE (TIME SPENT)	
			16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,624,690		16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,160,622	0	30.00
43.00	04300	NURSERY	118,437	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,198,351	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	595,765	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	915,614	0	54.00
57.00	05700	CT SCAN	102,418	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	98,123	0	58.00
60.00	06000	LABORATORY	884,226	0	60.00
65.00	06500	RESPIRATORY THERAPY	380,731	0	65.00
66.00	06600	PHYSICAL THERAPY	117,762	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	202,188	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	294,266	0	90.00
91.00	09100	EMERGENCY	1,367,176	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,435,679	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	122,580	0	192.00
194.00	07950	OTHER NONALLOWABLE	66,431	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)	941,618	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.109177	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,088	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005112	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

				Title XVIII	Hospital	Cost			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,565,189		6,565,189	0	0	30.00	
43.00	04300	NURSERY	287,064		287,064	0	0	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,160,437		5,160,437	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,474,224		1,474,224	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	252,772		252,772	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,001,396		3,001,396	0	0	54.00	
57.00	05700	CT SCAN	699,495		699,495	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	926,784		926,784	0	0	58.00	
60.00	06000	LABORATORY	3,405,936		3,405,936	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1,073,035	0	1,073,035	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,512,610	0	1,512,610	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	399,661		399,661	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	603,628		603,628	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,624,005		4,624,005	0	0	73.00	
76.00	03020	OTHER	0		0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	523,624		523,624	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	806,131		806,131	0	0	90.00	
91.00	09100	EMERGENCY	4,479,810		4,479,810	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	965,215		965,215	0	0	92.00	
200.00		Subtotal (see instructions)	36,761,016	0	36,761,016	0	0	200.00	
201.00		Less Observation Beds	965,215		965,215	0	0	201.00	
202.00		Total (see instructions)	35,795,801	0	35,795,801	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
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			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	5,143,896		5,143,896			30.00
43.00	04300	NURSERY	278,998		278,998			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,762,952	7,264,128	9,027,080	0.571662	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430,642	979,636	1,410,278	1.045343	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,614,517	5,954,105	7,568,622	0.033397	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,250	13,988,619	15,367,869	0.195303	0.000000	54.00
57.00	05700	CT SCAN	1,805,191	16,986,240	18,791,431	0.037224	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300,890	6,478,183	6,779,073	0.136712	0.000000	58.00
60.00	06000	LABORATORY	3,720,530	12,555,597	16,276,127	0.209260	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	601,800	1,703,102	2,304,902	0.465545	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,331,776	5,468,557	6,800,333	0.222432	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,273,706	1,945,876	3,219,582	0.124134	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,077,734	649,456	2,727,190	0.221337	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,838,746	12,187,320	16,026,066	0.288530	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	237,521	2,790,290	3,027,811	0.172938	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,285	3,566,172	3,568,457	0.225905	0.000000	90.00
91.00	09100	EMERGENCY	1,690,307	11,328,344	13,018,651	0.344107	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,175	770,423	1,123,598	0.859039	0.000000	92.00
200.00		Subtotal (see instructions)	27,843,916	104,616,048	132,459,964			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,843,916	104,616,048	132,459,964			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2018
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Part I
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	OTHER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
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11/26/2019 5:59 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	6,565,189		6,565,189	0	6,565,189	30.00	
43.00	04300	NURSERY	287,064		287,064	0	287,064	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,160,437		5,160,437	0	5,160,437	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,474,224		1,474,224	0	1,474,224	52.00	
53.00	05300	ANESTHESIOLOGY	252,772		252,772	0	252,772	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,001,396		3,001,396	0	3,001,396	54.00	
57.00	05700	CT SCAN	699,495		699,495	0	699,495	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	926,784		926,784	0	926,784	58.00	
60.00	06000	LABORATORY	3,405,936		3,405,936	0	3,405,936	60.00	
65.00	06500	RESPIRATORY THERAPY	1,073,035	0	1,073,035	0	1,073,035	65.00	
66.00	06600	PHYSICAL THERAPY	1,512,610	0	1,512,610	0	1,512,610	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	399,661		399,661	0	399,661	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	603,628		603,628	0	603,628	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,624,005		4,624,005	0	4,624,005	73.00	
76.00	03020	OTHER	0		0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	523,624		523,624	0	523,624	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	806,131		806,131	0	806,131	90.00	
91.00	09100	EMERGENCY	4,479,810		4,479,810	0	4,479,810	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	965,215		965,215	0	965,215	92.00	
200.00		Subtotal (see instructions)	36,761,016	0	36,761,016	0	36,761,016	200.00	
201.00		Less Observation Beds	965,215		965,215	0	965,215	201.00	
202.00		Total (see instructions)	35,795,801	0	35,795,801	0	35,795,801	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 5:59 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	5,143,896		5,143,896			30.00
43.00	04300	NURSERY	278,998		278,998			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,762,952	7,264,128	9,027,080	0.571662	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430,642	979,636	1,410,278	1.045343	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,614,517	5,954,105	7,568,622	0.033397	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,250	13,988,619	15,367,869	0.195303	0.000000	54.00
57.00	05700	CT SCAN	1,805,191	16,986,240	18,791,431	0.037224	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300,890	6,478,183	6,779,073	0.136712	0.000000	58.00
60.00	06000	LABORATORY	3,720,530	12,555,597	16,276,127	0.209260	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	601,800	1,703,102	2,304,902	0.465545	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,331,776	5,468,557	6,800,333	0.222432	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,273,706	1,945,876	3,219,582	0.124134	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,077,734	649,456	2,727,190	0.221337	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,838,746	12,187,320	16,026,066	0.288530	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	237,521	2,790,290	3,027,811	0.172938	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,285	3,566,172	3,568,457	0.225905	0.000000	90.00
91.00	09100	EMERGENCY	1,690,307	11,328,344	13,018,651	0.344107	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,175	770,423	1,123,598	0.859039	0.000000	92.00
200.00		Subtotal (see instructions)	27,843,916	104,616,048	132,459,964			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,843,916	104,616,048	132,459,964			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2018
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Part I
Date/Time Prepared:
11/26/2019 5:59 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
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	OTHER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/26/2019 5:59 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	691,210	9,027,080	0.076571	817,928	62,630	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,407	1,410,278	0.097433	0	0	52.00
53.00	05300	ANESTHESIOLOGY	34,809	7,568,622	0.004599	723,873	3,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,356	15,367,869	0.030281	747,949	22,649	54.00
57.00	05700	CT SCAN	52,829	18,791,431	0.002811	445,744	1,253	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	393,880	6,779,073	0.058102	183,734	10,675	58.00
60.00	06000	LABORATORY	283,120	16,276,127	0.017395	1,404,998	24,440	60.00
65.00	06500	RESPIRATORY THERAPY	141,017	2,304,902	0.061181	396,365	24,250	65.00
66.00	06600	PHYSICAL THERAPY	73,590	6,800,333	0.010822	680,300	7,362	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,984	3,219,582	0.020805	566,330	11,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,304	2,727,190	0.008912	1,144,556	10,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,732	16,026,066	0.021199	1,339,889	28,404	73.00
76.00	03020	OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	47,736	3,027,811	0.015766	54,027	852	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,456	3,568,457	0.011057	1,759	19	90.00
91.00	09100	EMERGENCY	364,260	13,018,651	0.027980	17,794	498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	157,976	1,123,598	0.140598	0	0	92.00
200.00		Total (lines 50 through 199)	3,313,666	127,037,070		8,525,246	208,343	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
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
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1350

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 5:59 pm

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	9,027,080	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,410,278	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,568,622	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,367,869	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	18,791,431	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,779,073	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	16,276,127	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,304,902	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,800,333	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,219,582	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,727,190	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,026,066	0.000000	73.00
76.00	03020	OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	3,027,811	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,568,457	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	13,018,651	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,123,598	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	127,037,070		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 5:59 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	817,928	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	723,873	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	747,949	0	0	0
57.00	05700	CT SCAN	0.000000	445,744	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	183,734	0	0	0
60.00	06000	LABORATORY	0.000000	1,404,998	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	396,365	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	680,300	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	566,330	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,144,556	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,339,889	0	0	0
76.00	03020	OTHER	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	54,027	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	1,759	0	0	0
91.00	09100	EMERGENCY	0.000000	17,794	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		8,525,246	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/26/2019 5:59 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	0.571662	0	2,328,511	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.045343	0	113,908	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033397	0	1,739,279	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195303	0	6,050,452	0	0	54.00
57.00	05700	CT SCAN	0.037224	0	7,675,298	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136712	0	2,431,915	0	0	58.00
60.00	06000	LABORATORY	0.209260	0	5,790,336	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.465545	0	733,792	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.222432	0	2,030,834	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.124134	0	820,848	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.221337	0	140,966	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288530	0	7,515,599	2,549	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172938	0	1,413,631	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.225905	0	1,129,229	0	0	90.00
91.00	09100	EMERGENCY	0.344107	0	4,560,052	2,112	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.859039	0	603,624	0	0	92.00
200.00		Subtotal (see instructions)		0	45,078,274	4,661	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	45,078,274	4,661	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/26/2019 5:59 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	1,331,121	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,073	0		52.00
53.00	05300	ANESTHESIOLOGY	58,087	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,181,671	0		54.00
57.00	05700	CT SCAN	285,705	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	332,472	0		58.00
60.00	06000	LABORATORY	1,211,686	0		60.00
65.00	06500	RESPIRATORY THERAPY	341,613	0		65.00
66.00	06600	PHYSICAL THERAPY	451,722	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,895	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,201	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,168,476	735		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	244,471	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	255,098	0		90.00
91.00	09100	EMERGENCY	1,569,146	727		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	518,537	0		92.00
200.00		Subtotal (see instructions)	10,201,974	1,462		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,201,974	1,462		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350

Period:

Worksheet D

Component CCN: 14-Z350

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/26/2019 5:59 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	0.571662	0	0	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.045343	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.033397	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195303	0	0	0	0	54.00	
57.00	05700	CT SCAN	0.037224	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136712	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.209260	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.465545	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.222432	0	0	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.124134	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.221337	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288530	0	0	0	0	73.00	
76.00	03020	OTHER	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.172938	0	0	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.225905	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.344107	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.859039	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: 14-1350

Period:

Worksheet D

Component CCN: 14-Z350

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/26/2019 5:59 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
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
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03020	OTHER	0	0					76.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 5:59 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)			5,025	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,562	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,824	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			228	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)			229	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			3	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)			3	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,470	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)			224	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)			224	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.23	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.23	20.00
21.00	Total general inpatient routine service cost (see instructions)			6,565,189	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)			466	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)			466	25.00
26.00	Total swing-bed cost (see instructions)			598,633	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,966,556	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)			5,966,556	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,307.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,230,464	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)			3,230,464	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1350

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

Worksheet D-1

Date/Time Prepared:
11/26/2019 5:59 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	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,035,492 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,265,956 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)					292,965 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					292,965 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					585,930 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)					738 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,307.88 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					965,215 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1350

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

Worksheet D-1

Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,074,516	6,565,189	0.163669	965,215	157,976	90.00
91.00	Nursing School cost	0	6,565,189	0.000000	965,215	0	91.00
92.00	Allied health cost	0	6,565,189	0.000000	965,215	0	92.00
93.00	All other Medical Education	0	6,565,189	0.000000	965,215	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 5:59 pm
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,514,658	
43.00	04300	NURSERY			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.571662	817,928	467,578
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.045343	0	0
53.00	05300	ANESTHESIOLOGY	0.033397	723,873	24,175
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195303	747,949	146,077
57.00	05700	CT SCAN	0.037224	445,744	16,592
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136712	183,734	25,119
60.00	06000	LABORATORY	0.209260	1,404,998	294,010
65.00	06500	RESPIRATORY THERAPY	0.465545	396,365	184,526
66.00	06600	PHYSICAL THERAPY	0.222432	680,300	151,320
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.124134	566,330	70,301
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.221337	1,144,556	253,333
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288530	1,339,889	386,598
76.00	03020	OTHER	0.000000	0	0
76.97	07697	CARDIAC REHABILITATION	0.172938	54,027	9,343
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.225905	1,759	397
91.00	09100	EMERGENCY	0.344107	17,794	6,123
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.859039	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,525,246	2,035,492
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		8,525,246	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1350 Component CCN: 14-Z350	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 5:59 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
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.571662	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.045343	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033397	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195303	21,427	4,185	54.00
57.00	05700	CT SCAN	0.037224	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136712	0	0	58.00
60.00	06000	LABORATORY	0.209260	74,434	15,576	60.00
65.00	06500	RESPIRATORY THERAPY	0.465545	24,629	11,466	65.00
66.00	06600	PHYSICAL THERAPY	0.222432	316,510	70,402	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.124134	26,983	3,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.221337	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288530	120,974	34,905	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172938	4,013	694	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.225905	126	28	90.00
91.00	09100	EMERGENCY	0.344107	808	278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.859039	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		589,904	140,884	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)		589,904		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3
			Component CCN: 14-Z350		Date/Time Prepared: 11/26/2019 5:59 pm
			Title XIX	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
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.571662	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.045343	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033397	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195303	0	54.00
57.00	05700	CT SCAN	0.037224	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136712	0	58.00
60.00	06000	LABORATORY	0.209260	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.465545	0	65.00
66.00	06600	PHYSICAL THERAPY	0.222432	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.124134	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.221337	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288530	0	73.00
76.00	03020	OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172938	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.225905	0	90.00
91.00	09100	EMERGENCY	0.344107	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.859039	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 5:59 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,203,436	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)		10,203,436	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)		10,305,470	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)		91,859	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		7,945,681	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)		2,267,930	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)		2,267,930	30.00
31.00	Primary payer payments		32	31.00
32.00	Subtotal (line 30 minus line 31)		2,267,898	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)		1,646,077	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,069,950	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,072,589	36.00
37.00	Subtotal (see instructions)		3,337,848	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,337,848	40.00
40.01	Sequestration adjustment (see instructions)		66,757	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,517,269	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-246,178	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: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/26/2019 5:59 pm

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,142,037		3,349,079	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	01/09/2019	168,190	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		168,190	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)		4,142,037		3,517,269	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		476,184		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		246,178	6.02
7.00	Total Medicare program liability (see instructions)		4,618,221		3,271,091	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: 14-1350

Period:

Worksheet E-1

Component CCN: 14-Z350

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

11/26/2019 5:59 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		662,963		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		662,963		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		53,297		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		716,260		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: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/26/2019 5:59 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: 14-1350

Period:

Worksheet E-2

Component CCN: 14-Z350

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 5:59 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)		591,789	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)		142,293	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		448	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)		734,082	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		734,082	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)		734,082	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,204	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)		730,878	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)		730,878	0	19.00
19.01	Sequestration adjustment (see instructions)		14,618	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		662,963	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)		53,297	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1350

Period:

Worksheet E-2

Component CCN: 14-Z350

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 5:59 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
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1350	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/26/2019 5:59 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		5,265,956	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)		5,265,956	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5,318,616	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)		5,318,616	19.00
20.00	Deductibles (exclude professional component)		702,699	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		4,615,917	22.00
23.00	Coinsurance		335	23.00
24.00	Subtotal (line 22 minus line 23)		4,615,582	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		149,058	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		96,888	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		89,397	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		4,712,470	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		4,712,470	30.00
30.01	Sequestration adjustment (see instructions)		94,249	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		4,142,037	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)		476,184	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: 14-1350

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

Worksheet G

Date/Time Prepared:
11/26/2019 5:59 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	4,911,124	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	17,982,210	0	0	0	4.00
5.00	Other receivable	16,748	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,193,642	0	0	0	6.00
7.00	Inventory	609,922	0	0	0	7.00
8.00	Prepaid expenses	225,232	0	0	0	8.00
9.00	Other current assets	445,586	0	0	0	9.00
10.00	Due from other funds	382,792	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,379,972	0	0	0	11.00
FIXED ASSETS						
12.00	Land	462,220	0	0	0	12.00
13.00	Land improvements	1,911,747	0	0	0	13.00
14.00	Accumulated depreciation	-1,441,231	0	0	0	14.00
15.00	Buildings	41,005,596	0	0	0	15.00
16.00	Accumulated depreciation	-20,519,522	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	24,600,524	0	0	0	23.00
24.00	Accumulated depreciation	-18,997,846	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,021,488	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	50,263,682	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	8,429,351	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	58,693,033	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	100,094,493	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,759,750	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,399,718	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,875,056	0	0	0	40.00
41.00	Deferred income	1,800	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	120,348	0	0	0	43.00
44.00	Other current liabilities	1,662,041	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,818,713	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,152,796	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,292,707	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,445,503	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,264,216	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	77,830,277				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)	77,830,277	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	100,094,493	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1350

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

Worksheet G-1

Date/Time Prepared:
11/26/2019 5:59 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		70,752,838		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,789,681				2.00
3.00	Total (sum of line 1 and line 2)		78,542,519		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		78,542,519		0		11.00
12.00	TEMP RESTRICTED	146,416		0		0	12.00
13.00	CHANGE IN NET ASSETS	565,826		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)		712,242		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		77,830,277		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TEMP RESTRICTED		0				12.00
13.00	CHANGE IN NET ASSETS		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: 14-1350

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2019 5:59 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,308,726		5,308,726	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	139,212		139,212	5.00
6.00	Swing bed - NF	1,828		1,828	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,449,766		5,449,766	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,449,766		5,449,766	17.00
18.00	Ancillary services	20,502,076	90,523,614	111,025,690	18.00
19.00	Outpatient services	2,056,671	15,822,066	17,878,737	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	57,564	241,507	299,071	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	28,066,077	106,587,187	134,653,264	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,103,594		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,103,594		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1350

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

Worksheet G-3

Date/Time Prepared:
11/26/2019 5:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	134,653,264	1.00
2.00	Less contractual allowances and discounts on patients' accounts	84,221,228	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,432,036	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,103,594	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,328,442	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	368,980	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	649	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	9,476	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	282	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	49,014	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	170,108	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,545,140	24.00
24.01	GRANTS	48,725	24.01
24.02	AFFILIATE COSTS	287,889	24.02
25.00	Total other income (sum of lines 6-24)	2,480,263	25.00
26.00	Total (line 5 plus line 25)	7,808,705	26.00
27.00	NON-OPERATING EXPENSES	23,375	27.00
27.01	GAIN/LOSS ON ASSET DISPOSAL	-4,351	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	19,024	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,789,681	29.00