

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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

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

Provider CCN: 14-4013

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

Worksheet S
Parts I-III
Date/Time Prepared:
8/7/2019 11:14 am

PART I - COST REPORT STATUS

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LINCOLN PRAIRIE (14-4013) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	-10,858,751	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0		0		0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	0	0	0	-10,858,751	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.

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	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.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	-10,858,751	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	0	0	0	-10,858,751	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4013		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 8/7/2019 11:14 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5230 S 6TH ST.			PO Box:				1.00	
2.00	City: SPRINGFIELD			State: IL		Zip Code: 62703		County: SANGAMON	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LINCOLN PRAIRIE	144013	44100	4	05/15/2008	N
4.00	Subprovider - IPF							N	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2018	04/30/2019	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4013		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 8/7/2019 11:14 am		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N	40.00	
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.									58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N				60.00	

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

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4013		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 8/7/2019 11:14 am	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00
						1.00	2.00
						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.				Y	B	0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				0		118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		0	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N		118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N		122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
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							

MCRIF32 - 15.6.166.3

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-4013	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part I Date/Time Prepared: 8/7/2019 11:14 am
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4013		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part II Date/Time Prepared: 8/7/2019 11:14 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
8/7/2019 11:14 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4013	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part II Date/Time Prepared: 8/7/2019 11:14 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
8/7/2019 11:14 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00	30.00	97	35,405	0.00	0	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)						
2.00						2.00
HMO and other (see instructions)						
3.00						3.00
HMO IPF Subprovider						
4.00						4.00
HMO IRF Subprovider						
5.00					0	5.00
Hospital Adults & Peds. Swing Bed SNF						
6.00					0	6.00
Hospital Adults & Peds. Swing Bed NF						
7.00		97	35,405	0.00	0	7.00
Total Adults and Peds. (exclude observation beds) (see instructions)						
8.00						8.00
INTENSIVE CARE UNIT						
9.00						9.00
CORONARY CARE UNIT						
10.00						10.00
BURN INTENSIVE CARE UNIT						
11.00						11.00
SURGICAL INTENSIVE CARE UNIT						
12.00						12.00
OTHER SPECIAL CARE (SPECIFY)						
13.00						13.00
NURSERY						
14.00		97	35,405	0.00	0	14.00
Total (see instructions)						
15.00					0	15.00
CAH visits						
16.00						16.00
SUBPROVIDER - IPF						
17.00						17.00
SUBPROVIDER - IRF						
18.00						18.00
SUBPROVIDER						
19.00						19.00
SKILLED NURSING FACILITY						
20.00						20.00
NURSING FACILITY						
21.00	46.00	0	0			21.00
OTHER LONG TERM CARE						
22.00						22.00
HOME HEALTH AGENCY						
23.00						23.00
AMBULATORY SURGICAL CENTER (D.P.)						
24.00						24.00
HOSPICE						
24.10	30.00					24.10
HOSPICE (non-distinct part)						
25.00	99.00				0	25.00
CMHC - CMHC						
25.10	99.10				0	25.10
CMHC - CORF						
26.00						26.00
RURAL HEALTH CLINIC						
26.25	89.00				0	26.25
FEDERALLY QUALIFIED HEALTH CENTER						
27.00		97				27.00
Total (sum of lines 14-26)						
28.00					0	28.00
Observation Bed Days						
29.00						29.00
Ambulance Trips						
30.00						30.00
Employee discount days (see instruction)						
31.00						31.00
Employee discount days - IRF						
32.00		0	0			32.00
Labor & delivery days (see instructions)						
32.01						32.01
Total ancillary labor & delivery room outpatient days (see instructions)						
33.00						33.00
LTCH non-covered days						
33.01						33.01
LTCH site neutral days and discharges						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
8/7/2019 11:14 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	11,019	26,294			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	11,019	26,294			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	11,019	26,294	0.00	0.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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	0.00	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
8/7/2019 11:14 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	0	694	2,308	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	0	694	2,308	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4013

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

Worksheet A

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		971,153	971,153	0	971,153	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		115,502	115,502	588	116,090	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	110,715	1,578,482	1,689,197	0	1,689,197	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,149,454	4,320,841	6,470,295	-324,796	6,145,499	5.00
7.00	00700	OPERATION OF PLANT	170,460	779,571	950,031	0	950,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,483	127,483	0	127,483	8.00
9.00	00900	HOUSEKEEPING	0	226,956	226,956	0	226,956	9.00
10.00	01000	DIETARY	249,746	372,323	622,069	0	622,069	10.00
13.00	01300	NURSING ADMINISTRATION	942,588	15,782	958,370	0	958,370	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,906	135,102	234,008	0	234,008	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,102,962	384,361	4,487,323	0	4,487,323	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	480,968	14,905	495,873	0	495,873	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,305,799	9,042,461	17,348,260	-324,208	17,024,052	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	117,241	494	117,735	0	117,735	194.01
194.02	07952	COMMUNITY RELATIONS	0	0	0	324,208	324,208	194.02
194.03	07953	PHP MEALS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	8,423,040	9,042,955	17,465,995	0	17,465,995	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4013

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

Worksheet A

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-148,323	822,830	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	49,732	165,822	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-170,330	1,518,867	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,560,214	3,585,285	5.00
7.00	00700	OPERATION OF PLANT	0	950,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,483	8.00
9.00	00900	HOUSEKEEPING	0	226,956	9.00
10.00	01000	DIETARY	-4,825	617,244	10.00
13.00	01300	NURSING ADMINISTRATION	0	958,370	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,547	224,461	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,487,323	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	IOP	0	495,873	93.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,843,507	14,180,545	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	117,735	194.01
194.02	07952	COMMUNITY RELATIONS	0	324,208	194.02
194.03	07953	PHP MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,843,507	14,622,488	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet Non-CMS W
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
46.00	OTHER LONG TERM CARE	04600		46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
93.00	IOP	04950		93.00
OTHER REIMBURSABLE COST CENTERS				
99.00	CMHC	09900		99.00
99.10	CORF	09910		99.10
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
191.00	RESEARCH	19100		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.01	EDUCATION	07951		194.01
194.02	COMMUNITY RELATIONS	07952		194.02
194.03	PHP MEALS	07953		194.03
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

Provider CCN: 14-4013

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

Worksheet A-6

Date/Time Prepared:
8/7/2019 11:14 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - RENT				1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	588	
	0		0	588	
1.00	B - COMMUNITY RELATIONS				1.00
	COMMUNITY RELATIONS	194.02	257,314	66,894	
	0		257,314	66,894	
500.00	Grand Total: Increases		257,314	67,482	500.00

	Decreases						07/2010 - 11/14 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RENT						
	ADMINISTRATIVE & GENERAL	5.00	0	588	10		1.00
	0		0	588			
1.00	B - COMMUNITY RELATIONS						
	ADMINISTRATIVE & GENERAL	5.00	257,314	66,894	0		1.00
	0		257,314	66,894			
500.00	Grand Total: Decreases		257,314	67,482			500.00

RECLASSIFICATIONS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/7/2019 11:14 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - RENT									
1.00	CAP REL COSTS-MVBLE	2.00	0	588	ADMINISTRATIVE &	5.00	0	588	1.00
	EQUIP				GENERAL				
	0		0	588	0		0	588	
B - COMMUNITY RELATIONS									
1.00	COMMUNITY RELATIONS	194.02	257,314	66,894	ADMINISTRATIVE &	5.00	257,314	66,894	1.00
					GENERAL				
	0		257,314	66,894	0		257,314	66,894	
500.00	Grand Total:		257,314	67,482	Grand Total:		257,314	67,482	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part I
Date/Time Prepared:
8/7/2019 11:14 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part II
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	773,196	0	0	18,531	179,426	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	113,016	0	0	2,486	0	2.00
3.00	Total (sum of lines 1-2)	886,212	0	0	21,017	179,426	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	971,153				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	115,502				2.00
3.00	Total (sum of lines 1-2)	0	1,086,655				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part III
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,707,331	0	13,707,331	0.920097	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,190,373	0	1,190,373	0.079903	0	2.00
3.00	Total (sum of lines 1-2)	14,897,704	0	14,897,704	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	624,873	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	162,748	588	2.00
3.00	Total (sum of lines 1-2)	0	0	0	787,621	588	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	18,531	179,426	0	822,830	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,486	0	0	165,822	2.00
3.00	Total (sum of lines 1-2)	0	21,017	179,426	0	988,652	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4013

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

Worksheet A-8

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-38,894	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,557,781			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	-222,442			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-4,825	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,547	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-148,323	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	49,732	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4013

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

Worksheet A-8

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC ADMIN REVENUE	B	-27,834	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	REBATES - ADD BACK	A	38,894	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN BILLING	A	-123,803	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	MARKETING	A	-12,748	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	LOBBYING	A	-3,571	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	BAD DEBTS	A	10,220	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	DONATIONS	A	-5,182	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	PATIENT TRANSPORTATION	A	-520,775	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	SPORTING EVENTS	A	-3,500	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	GAIN/LOSS ON DISPOSAL	A	-1,178	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	STATE INCOME TAX	A	-261,950	ADMINISTRATIVE & GENERAL	5.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,843,507				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-4013

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

Worksheet A-8-1

Date/Time Prepared:
8/7/2019 11:14 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	721,844	782,120 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	INTERCO INTEREST	0	7,150 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	0	166,830 3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	NRO MGMT FEE	12,358	12,358 3.01
4.00		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	97,118	85,304 4.00
5.00	0				831,320	1,053,762 5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-4013

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

Worksheet A-8-1

Date/Time Prepared:
8/7/2019 11:14 am

	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	-60,276	0		1.00
2.00	-7,150	0		2.00
3.00	-166,830	0		3.00
3.01	0	0		3.01
4.00	11,814	0		4.00
5.00	-222,442			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-4013

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

Worksheet A-8-2

Date/Time Prepared:
8/7/2019 11:14 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,557,781	1,557,781	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,557,781	1,557,781	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,557,781		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,557,781		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	822,830	822,830			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	165,822	165,822			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,518,867	3,318	669	1,522,854	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,585,285	79,375	15,996	346,648	4,027,304
7.00	00700	OPERATION OF PLANT	950,031	152,704	30,774	31,229	1,164,738
8.00	00800	LAUNDRY & LINEN SERVICE	127,483	0	0	0	127,483
9.00	00900	HOUSEKEEPING	226,956	5,299	1,068	0	233,323
10.00	01000	DIETARY	617,244	29,551	5,955	45,754	698,504
13.00	01300	NURSING ADMINISTRATION	958,370	4,222	851	172,686	1,136,129
16.00	01600	MEDICAL RECORDS & LIBRARY	224,461	6,072	1,224	18,120	249,877
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,487,323	490,572	98,863	751,682	5,828,440
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
93.00	04950	IOP	495,873	47,661	9,605	88,115	641,254
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,180,545	818,774	165,005	1,454,234	14,107,052
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	117,735	2,215	446	21,479	141,875
194.02	07952	COMMUNITY RELATIONS	324,208	1,841	371	47,141	373,561
194.03	07953	PHP MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	14,622,488	822,830	165,822	1,522,854	14,622,488

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,027,304					5.00
7.00	00700	OPERATION OF PLANT	442,725	1,607,463				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,457	0	175,940			8.00
9.00	00900	HOUSEKEEPING	88,688	14,499	0	336,510		9.00
10.00	01000	DIETARY	265,506	80,863	0	17,082	1,061,955	10.00
13.00	01300	NURSING ADMINISTRATION	431,851	11,552	0	2,440	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,980	16,615	0	3,510	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,215,431	1,342,412	175,940	283,583	983,560	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	243,745	130,422	0	27,551	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,831,383	1,596,363	175,940	334,166	983,560	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	53,928	6,061	0	1,280	0	194.01
194.02	07952	COMMUNITY RELATIONS	141,993	5,039	0	1,064	0	194.02
194.03	07953	PHP MEALS	0	0	0	0	78,395	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,027,304	1,607,463	175,940	336,510	1,061,955	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	1,581,972					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	364,982				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,581,972	334,012	12,745,350	0	12,745,350	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	0	30,970	1,073,942	0	1,073,942	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,581,972	364,982	13,819,292	0	13,819,292	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	203,144	0	203,144	194.01
194.02	07952	COMMUNITY RELATIONS	0	0	521,657	0	521,657	194.02
194.03	07953	PHP MEALS	0	0	78,395	0	78,395	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,581,972	364,982	14,622,488	0	14,622,488	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-4013

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

Worksheet Non-CMS W

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
1.00	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	P	PT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	2	MEALS	10.00
13.00	NURSING ADMINISTRATION	P	PT DAYS	13.00
16.00	MEDICAL RECORDS & LIBRARY	C	CHARGES	16.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

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

Worksheet B-1

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	94,728					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		94,728				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	382	382	8,312,325			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,138	9,138	1,892,140	-4,027,304	10,595,184	5.00
7.00	00700	OPERATION OF PLANT	17,580	17,580	170,460	0	1,164,738	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	127,483	8.00
9.00	00900	HOUSEKEEPING	610	610	0	0	233,323	9.00
10.00	01000	DIETARY	3,402	3,402	249,746	0	698,504	10.00
13.00	01300	NURSING ADMINISTRATION	486	486	942,588	0	1,136,129	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	699	699	98,906	0	249,877	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,477	56,477	4,102,962	0	5,828,440	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	IOP	5,487	5,487	480,968	0	641,254	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,261	94,261	7,937,770	-4,027,304	10,079,748	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	255	255	117,241	0	141,875	194.01
194.02	07952	COMMUNITY RELATIONS	212	212	257,314	0	373,561	194.02
194.03	07953	PHP MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	822,830	165,822	1,522,854		4,027,304	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.686238	1.750507	0.183204		0.380107	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,987		96,279	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000480		0.009087	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

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

Worksheet B-1

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS)	NURSING ADMINISTRATION (PT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	67,628				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,294			8.00
9.00	00900	HOUSEKEEPING	610	0	67,018		9.00
10.00	01000	DIETARY	3,402	0	3,402	93,686	10.00
13.00	01300	NURSING ADMINISTRATION	486	0	486	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	699	0	699	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,477	26,294	56,477	86,770	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	IOP	5,487	0	5,487	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,161	26,294	66,551	86,770	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	255	0	255	0	194.01
194.02	07952	COMMUNITY RELATIONS	212	0	212	0	194.02
194.03	07953	PHP MEALS	0	0	0	6,916	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,607,463	175,940	336,510	1,061,955	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.769193	6.691260	5.021188	11.335258	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	194,144	1,158	10,238	52,259	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.870764	0.044040	0.152765	0.557810	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4013

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

Worksheet B-1

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		44,208,079	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		0	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
93.00	04950	IOP	93.00
		3,751,266	
OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
		0	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		44,208,079	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	COMMUNITY RELATIONS	194.02
194.03	07953	PHP MEALS	194.03
		0	
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		364,982	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.008256	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		11,728	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000265	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/7/2019 11:14 am

				Title XVIII		Hospital		8/7/2019 11:14 am	
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	12,745,350		12,745,350	0	0	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00	
60.00	06000	LABORATORY	0		0	0	0	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	90.00	
93.00	04950	IOP	1,073,942		1,073,942	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
99.00	09900	CMHC	0		0		0	99.00	
99.10	09910	CORF	0		0		0	99.10	
200.00		Subtotal (see instructions)	13,819,292	0	13,819,292	0	0	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	13,819,292	0	13,819,292	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/7/2019 11:14 am

			Title XVIII			Hospital			
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,456,813		40,456,813			30.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
93.00	04950	IOP	0	3,751,266	3,751,266	0.286288	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0			99.00	
99.10	09910	CORF	0	0	0			99.10	
200.00		Subtotal (see instructions)	40,456,813	3,751,266	44,208,079			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	40,456,813	3,751,266	44,208,079			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/7/2019 11:14 am

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/7/2019 11:14 am

				Title XIX		Hospital		Cost		
Cost Center Description				Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
						Total Costs	RCE	Total Costs		
							Disallowance			
1.00				2.00	3.00	4.00	5.00			
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	12,745,350		12,745,350	0	12,745,350	30.00		
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00		
	ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00		
60.00	06000	LABORATORY	0		0	0	0	60.00		
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00		
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00		
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	90.00		
93.00	04950	IOP	1,073,942		1,073,942	0	1,073,942	93.00		
	OTHER REIMBURSABLE COST CENTERS									
99.00	09900	CMHC	0		0		0	99.00		
99.10	09910	CORF	0		0		0	99.10		
200.00		Subtotal (see instructions)	13,819,292	0	13,819,292	0	13,819,292	200.00		
201.00		Less Observation Beds	0		0		0	201.00		
202.00		Total (see instructions)	13,819,292	0	13,819,292	0	13,819,292	202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
8/7/2019 11:14 am

			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	40,456,813		40,456,813			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
93.00	04950	IOP	0	3,751,266	3,751,266	0.286288	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	40,456,813	3,751,266	44,208,079			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,456,813	3,751,266	44,208,079			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN:14-4013	Period: From 05/01/2018 To 04/30/2019	Worksheet C Part I Date/Time Prepared: 8/7/2019 11:14 am
				Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
93.00	04950	IOP	0.000000			93.00
	OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4013	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 8/7/2019 11:14 am
		Title XIX	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		26,294	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,294	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)		26,294	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		11,019	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,745,350	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12,745,350	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)		12,745,350	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)		484.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,341,130	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)		5,341,130	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-4013

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

Worksheet D-1

Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,341,130	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4013		Period: From 05/01/2018 To 04/30/2019		Worksheet D-1 Date/Time Prepared: 8/7/2019 11:14 am	
		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	892,737	12,745,350	0.070044	0	0	90.00
91.00	Nursing School cost	0	12,745,350	0.000000	0	0	91.00
92.00	Allied health cost	0	12,745,350	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,745,350	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4013	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 8/7/2019 11:14 am	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		16,973,719		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 IOP	0.286288	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4013	Period: From 05/01/2018 To 04/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 8/7/2019 11:14 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		5,341,130		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,341,130	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,341,130	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		16,973,719		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		16,973,719	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		16,973,719	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		11,632,589	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,341,130	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,341,130	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,341,130	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,341,130	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		5,341,130	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		5,341,130	0	40.00
41.00	Interim payments		16,199,881	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-10,858,751	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

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

Provider CCN: 14-4013

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

Worksheet G

Date/Time Prepared:
8/7/2019 11:14 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-55,075	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	7,180,658	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	28,373	0	0	0	7.00
8.00	Prepaid expenses	52,520	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,206,476	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,203,487	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	14,878,536	0	0	0	15.00
16.00	Accumulated depreciation	-6,184,971	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,298,965	0	0	0	23.00
24.00	Accumulated depreciation	-795,474	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)	12,400,543	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,381,478	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,381,478	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,988,497	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	316,071	0	0	0	37.00
38.00	Salaries, wages, and fees payable	968,262	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	-1,025,644	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-96,728,265	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-96,469,576	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-96,469,576	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	118,458,073				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)	118,458,073	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,988,497	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4013

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

Worksheet G-1

Date/Time Prepared:
8/7/2019 11:14 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		102,363,720		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,094,353				2.00
3.00	Total (sum of line 1 and line 2)		118,458,073		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)		118,458,073		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		118,458,073		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-4013

Period:
From 05/01/2018
To 04/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/7/2019 11:14 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	40,456,813		40,456,813	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	40,456,813		40,456,813	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)	40,456,813		40,456,813	17.00
18.00	Ancillary services	0		0	18.00
19.00	Outpatient services	0	3,751,266	3,751,266	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,456,813	3,751,266	44,208,079	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,465,995		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	PHYSICIAN REVENUE	3,117,650			37.00
38.00	EDUCATION REVENUE	463,122			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)		3,580,772		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,885,223		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4013

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

Worksheet G-3

Date/Time Prepared:
8/7/2019 11:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,208,079	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,270,707	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,937,372	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,885,223	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,052,149	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	42,206	24.00
25.00	Total other income (sum of lines 6-24)	42,206	25.00
26.00	Total (line 5 plus line 25)	16,094,355	26.00
27.00	ROUNDING	2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,094,353	29.00