

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet S Parts I-III Date/Time Prepared: 9/24/2020 8:14 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/24/2020	Time: 8:14 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (14-1312) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) LORI GUTIERREZ

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	366,849	336,138	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	111,577	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	478,426	336,138	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/24/2020 8:14 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 900 NORTH 2ND STREET			PO Box:				1.00				
2.00	City: ROCHELLE			State: IL		Zip Code: 61068		County: OGLE				
		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			ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	N	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	O	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2019	04/30/2020		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/24/2020 8:14 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.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/24/2020 8:14 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/24/2020 8:14 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	Y
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/24/2020 8:14 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	296,185	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/24/2020 8:14 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 9/24/2020 8:14 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/06/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/24/2020 8:14 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.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4389	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/24/2020 8:14 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.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/24/2020 8:14 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	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	13	4,758	19,488.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		13	4,758	19,488.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		17	6,222	19,488.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		17			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/24/2020 8:14 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)	476	75	812			1.00
2.00	HMO and other (see instructions)	84	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	127	0	127			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)	603	75	939			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	603	75	939	0.00	280.50	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	280.50	27.00
28.00	Observation Bed Days		0	479			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/24/2020 8:14 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	177	38	328	1.00
2.00 HMO and other (see instructions)			30	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	177	38	328	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet S-10

Date/Time Prepared:
9/24/2020 8:14 am

			9/24/2020 8:14 am	
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.437808	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,333,254	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,594,567	5.00
6.00	Medicaid charges		8,130,703	6.00
7.00	Medicaid cost (line 1 times line 6)		3,559,687	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		631,866	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		12,250	9.00
10.00	Stand-alone CHIP charges		55,538	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		24,315	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		12,065	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		684,890	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		643,931	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,256,434	185,337	1,441,771
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	550,077	185,337	735,414
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	550,077	185,337	735,414
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,794,473	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		542,999	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		835,383	
28.00	Non-Medicare bad debt expense (see instructions)		959,090	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		712,281	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,447,695	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,091,626	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,131,486	1,131,486	597,138	1,728,624
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,249,742	1,249,742	-323,790	925,952
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	197,800	4,005,868	4,203,668	0	4,203,668
5.01	00570	ADMITTING	342,541	29,640	372,181	122,634	494,815
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	503,560	340,593	844,153	0	844,153
5.03	00590	OTHER ADMIN & GENERAL	1,614,781	2,882,921	4,497,702	21,858	4,519,560
7.00	00700	OPERATION OF PLANT	346,701	861,087	1,207,788	0	1,207,788
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	67,644	67,644
9.00	00900	HOUSEKEEPING	380,636	135,034	515,670	-62,389	453,281
10.00	01000	DIETARY	282,235	348,003	630,238	-487,659	142,579
11.00	01100	CAFETERIA	0	0	0	487,659	487,659
13.00	01300	NURSING ADMINISTRATION	314,217	29,710	343,927	0	343,927
14.00	01400	CENTRAL SERVICES & SUPPLY	148,943	28,908	177,851	-5,255	172,596
15.00	01500	PHARMACY	242,491	1,206,831	1,449,322	-1,036,286	413,036
16.00	01600	MEDICAL RECORDS & LIBRARY	483,791	117,482	601,273	0	601,273
17.00	01700	SOCIAL SERVICE	228,567	28,380	256,947	0	256,947
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,645,703	654,690	2,300,393	-10	2,300,383
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	826,768	531,778	1,358,546	0	1,358,546
53.00	05300	ANESTHESIOLOGY	0	237,374	237,374	0	237,374
54.00	05400	RADIOLOGY-DIAGNOSTIC	767,660	1,237,777	2,005,437	-55,683	1,949,754
60.00	06000	LABORATORY	870,685	953,257	1,823,942	-2,894	1,821,048
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	41,418	41,418	4,812	46,230
64.00	06400	INTRAVENOUS THERAPY	210,444	12,190	222,634	0	222,634
65.00	06500	RESPIRATORY THERAPY	12,000	966,370	978,370	-49,981	928,389
66.00	06600	PHYSICAL THERAPY	158,369	648,054	806,423	-104,957	701,466
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	104,957	104,957
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,570	14,570	0	14,570
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,721	89,721	0	89,721
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,091,983	1,091,983
76.00	03950	DIABETIC SERVICES	26,724	1,431	28,155	0	28,155
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	1,487,345	1,031,939	2,519,284	-1,918	2,517,366
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		203,918	203,918	-203,918	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,091,961	19,020,172	30,112,133	163,945	30,276,078
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
194.00	07950	OCCUPATIONAL HEALTH	280,132	125,648	405,780	0	405,780
194.01	07951	FOUNDATION	0	0	0	0	0
194.02	07952	PHYSICIANS CLINICS	155,186	4,848	160,034	-160,034	0
194.03	07953	HEALTH & WELLNESS CENTER	1,478,076	240,855	1,718,931	-3,911	1,715,020
200.00		TOTAL (SUM OF LINES 118 through 199)	13,005,355	19,391,523	32,396,878	0	32,396,878

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/24/2020 8:14 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	-203,918	1,524,706	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-65,334	860,618	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-27,213	4,176,455	4.00
5.01	00570	ADMITTING	0	494,815	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	844,153	5.02
5.03	00590	OTHER ADMIN & GENERAL	-1,047,034	3,472,526	5.03
7.00	00700	OPERATION OF PLANT	-783	1,207,005	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,644	8.00
9.00	00900	HOUSEKEEPING	0	453,281	9.00
10.00	01000	DIETARY	0	142,579	10.00
11.00	01100	CAFETERIA	-101,324	386,335	11.00
13.00	01300	NURSING ADMINISTRATION	-4,230	339,697	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	172,596	14.00
15.00	01500	PHARMACY	-16,553	396,483	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,322	596,951	16.00
17.00	01700	SOCIAL SERVICE	0	256,947	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-493,800	1,806,583	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-21,000	1,337,546	50.00
53.00	05300	ANESTHESIOLOGY	-233,188	4,186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,949,754	54.00
60.00	06000	LABORATORY	0	1,821,048	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,230	62.00
64.00	06400	INTRAVENOUS THERAPY	-400	222,234	64.00
65.00	06500	RESPIRATORY THERAPY	0	928,389	65.00
66.00	06600	PHYSICAL THERAPY	-36,899	664,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,957	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,091,983	73.00
76.00	03950	DIABETIC SERVICES	0	28,155	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-693,873	1,823,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,949,871	27,326,207	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	405,780	194.00
194.01	07951	FOUNDATION	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,715,020	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,949,871	29,447,007	200.00

RECLASSIFICATIONS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
9/24/2020 8:14 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	69,430	1.00
	0		0	69,430	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	218,385	269,274	1.00
	0		218,385	269,274	
	C - RECEPTIONIST-NURSING				
1.00	ADMITTING	5.01	118,919	3,715	1.00
2.00	RESPIRATORY THERAPY	65.00	36,267	1,133	2.00
	0		155,186	4,848	
	D - FITNESS CENTER				
1.00	OTHER ADMIN & GENERAL	5.03	0	87,377	1.00
	0		0	87,377	
	E - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	203,918	1.00
	0		0	203,918	
	F - EKGS				
1.00	LABORATORY	60.00	1,918	0	1.00
	0		1,918	0	
	G - FIXED EQUIPMENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	344,223	1.00
	0		0	344,223	
	H - OCCUPATIONAL THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	19,644	85,313	1.00
	0		19,644	85,313	
	I - LAUNDRY AND LINEN				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	67,644	1.00
2.00		0.00	0	0	2.00
	0		0	67,644	
	J - PHYSICIAN ADMIN COSTS				
1.00	OTHER ADMIN & GENERAL	5.03	3,911	0	1.00
	0		3,911	0	
	K - BLOOD BANK SALARIES				
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	4,812	0	1.00
	0		4,812	0	
	L - DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,091,983	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	1,091,983	
500.00	Grand Total: Increases		403,856	2,224,010	500.00

RECLASSIFICATIONS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
9/24/2020 8:14 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	A - PROPERTY INSURANCE					1.00
	OTHER ADMIN & GENERAL	5.03	0	69,430	12	
	0		0	69,430		
1.00	B - CAFETERIA					1.00
	DIETARY	10.00	218,385	269,274	0	
	0		218,385	269,274		
1.00	C - RECEPTIONIST-NURSING					1.00
	PHYSICIANS CLINICS	194.02	155,186	4,848	0	
	2.00	0	0	0	0	
1.00	D - FITNESS CENTER					1.00
	RESPIRATORY THERAPY	65.00	0	87,377	0	
	0		0	87,377		
1.00	E - INTEREST EXPENSE					1.00
	INTEREST EXPENSE	113.00	0	203,918	11	
	0		0	203,918		
1.00	F - EKGS					1.00
	EMERGENCY	91.00	1,918	0	0	
	0		1,918	0		
1.00	G - FIXED EQUIPMENT					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	344,223	9	
	0		0	344,223		
1.00	H - OCCUPATIONAL THERAPY					1.00
	PHYSICAL THERAPY	66.00	19,644	85,313	0	
	0		19,644	85,313		
1.00	I - LAUNDRY AND LINEN					1.00
	HOUSEKEEPING	9.00	0	62,389		
	2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,255	
1.00	J - PHYSICIAN ADMIN COSTS					1.00
	HEALTH & WELLNESS CENTER	194.03	3,911	0	0	
	0		3,911	0		
1.00	K - BLOOD BANK SALARIES					1.00
	LABORATORY	60.00	4,812	0	0	
	0		4,812	0		
1.00	L - DRUG COSTS					1.00
	PHARMACY	15.00	0	1,036,286	0	
	RADIOLOGY-DIAGNOSTIC	54.00	0	55,683	0	
	ADULTS & PEDIATRICS	30.00	0	10	0	
	4.00	RESPIRATORY THERAPY	65.00	0	4	
500.00	Grand Total: Decreases		403,856	2,224,010		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
9/24/2020 8:14 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	3,684,161	0	0	0	0	1.00	
2.00	Land Improvements	1,463,837	0	0	0	0	2.00	
3.00	Buildings and Fixtures	20,853,344	1,592,799	0	1,592,799	114,636	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	3,336,366	399,717	0	399,717	490	5.00	
6.00	Movable Equipment	9,917,367	468,643	0	468,643	833,802	6.00	
7.00	HIT designated Assets	3,569,918	0	0	0	104,988	7.00	
8.00	Subtotal (sum of lines 1-7)	42,824,993	2,461,159	0	2,461,159	1,053,916	8.00	
9.00	Reconciling Items	661,925	-535,978	0	-535,978	0	9.00	
10.00	Total (line 8 minus line 9)	42,163,068	2,997,137	0	2,997,137	1,053,916	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,684,161	0				1.00	
2.00	Land Improvements	1,463,837	0				2.00	
3.00	Buildings and Fixtures	22,331,507	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	3,735,593	0				5.00	
6.00	Movable Equipment	9,552,208	0				6.00	
7.00	HIT designated Assets	3,464,930	0				7.00	
8.00	Subtotal (sum of lines 1-7)	44,232,236	0				8.00	
9.00	Reconciling Items	125,947	0				9.00	
10.00	Total (line 8 minus line 9)	44,106,289	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
9/24/2020 8:14 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	1,114,385	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,249,742	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,364,127	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	17,101	1,131,486				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,249,742				2.00
3.00	Total (sum of lines 1-2)	17,101	2,381,228				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
9/24/2020 8:14 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	31,215,099	0	31,215,099	0.705709	48,997	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,017,139	0	13,017,139	0.294291	20,433	2.00
3.00	Total (sum of lines 1-2)	44,232,238	0	44,232,238	1.000000	69,430	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	48,997	1,458,608	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,433	840,185	0	2.00
3.00	Total (sum of lines 1-2)	0	0	69,430	2,298,793	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	48,997	0	17,101	1,524,706	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,433	0	0	860,618	2.00
3.00	Total (sum of lines 1-2)	0	69,430	0	17,101	2,385,324	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/24/2020 8:14 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 #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-203,918	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-783	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,442,261			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-101,324	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,322	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-63,979	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PHYSICAL THERAPY RENTAL INCOME	B	-36,899	PHYSICAL THERAPY	66.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/24/2020 8:14 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 CREDENTIALING	B	-10,100	OTHER ADMIN & GENERAL	5.03	0	33.01
33.02 MISCELLANEOUS INCOME	B	-5,722	OTHER ADMIN & GENERAL	5.03	0	33.02
33.03 FITNESS CENTER	B	-47,337	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04 MARKETING EXPENSE	A	-227,206	OTHER ADMIN & GENERAL	5.03	0	33.04
33.05 LOBBYING EXPENSE	A	-13,387	OTHER ADMIN & GENERAL	5.03	0	33.05
33.06 PROPERTY TAX	A	-13,000	OTHER ADMIN & GENERAL	5.03	0	33.06
33.07 ASSESSMENT TAX	A	-726,796	OTHER ADMIN & GENERAL	5.03	0	33.07
33.08 PHYSICIAN BENEFITS	A	-15,577	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.10 TELEPHONE SERVICES	A	-687	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11 TELEPHONE SERVICES	A	-2,336	OTHER ADMIN & GENERAL	5.03	0	33.11
33.12 TELEPHONE SERVICES	A	-1,355	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13 MARKETING BENEFITS	A	-11,112	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14 MISC REVENUE - DEF COMP	B	163	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15 EDUCATION CLASS INCOME	B	-4,230	NURSING ADMINISTRATION	13.00	0	33.15
33.17 DONATIONS	A	-1,150	OTHER ADMIN & GENERAL	5.03	0	33.17
33.18 340B RETAIL PHARMACY COSTS	A	-16,553	PHARMACY	15.00	0	33.18
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,949,871				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-2

Date/Time Prepared:
9/24/2020 8:14 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	30.00	ADULTS & PEDIATRICS	493,800	493,800	0	0	0	1.00
2.00	50.00	OPERATING ROOM	21,000	21,000	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	233,188	233,188	0	0	0	3.00
4.00	64.00	INTRAVENOUS THERAPY	400	400	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	12,000	0	12,000	0	0	5.00
6.00	91.00	EMERGENCY	767,313	492,004	275,309	0	0	6.00
7.00	91.00	EMERGENCY	47,871	0	47,871	0	0	7.00
8.00	91.00	EMERGENCY	173,341	173,341	0	0	0	8.00
9.00	91.00	EMERGENCY	28,528	28,528	0	0	0	9.00
10.00	5.03	OTHER ADMIN & GENERAL	3,911	0	3,911	0	0	10.00
200.00			1,781,352	1,442,261	339,091		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	5.03	OTHER ADMIN & GENERAL	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	30.00	ADULTS & PEDIATRICS	0	0	0	493,800		1.00
2.00	50.00	OPERATING ROOM	0	0	0	21,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	233,188		3.00
4.00	64.00	INTRAVENOUS THERAPY	0	0	0	400		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	492,004		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	173,341		8.00
9.00	91.00	EMERGENCY	0	0	0	28,528		9.00
10.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0		10.00
200.00			0	0	0	1,442,261		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/24/2020 8:14 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					35	1.00
2.00	Line 1 multiplied by 15 hours per week					525	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					245	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.80	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	267.00	4,515.86	0.00	1,791.08	0.00	9.00
10.00	AHSEA (see instructions)	95.63	83.16	40.54	16.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.58	41.58	20.27			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					25,533	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					375,539	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					401,072	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					28,657	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					429,729	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					429,729	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					10,187	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,187	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,421	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,608	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,608	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/24/2020 8:14 am		
		Physical Therapy				Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.16	40.54	16.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						429,729	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						11,608	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						441,337	63.00
64.00	Total cost of outside supplier services (from your records)						326,609	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						10,187	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,421	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						11,608	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,421	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						1,421	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/24/2020 8:14 am	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.80	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	13,332.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.29	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.65	32.65	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					870,463	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					870,463	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					870,463	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					870,463	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					11,917	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					11,917	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,117	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,034	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					14,034	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/24/2020 8:14 am		
				Respiratory Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.29	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						870,463	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						14,034	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						884,497	63.00
64.00	Total cost of outside supplier services (from your records)						859,515	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						11,917	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,117	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						14,034	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,117	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						2,117	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/24/2020 8:14 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					35	1.00
2.00	Line 1 multiplied by 15 hours per week					525	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					245	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.80	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	570.67	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.41	39.41	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					44,975	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					44,975	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					44,975	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					44,975	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,655	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,655	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,421	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,076	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,076	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/24/2020 8:14 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.81	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
							1.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)						44,975
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						11,076
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0
60.00	Overtime allowance (from column 5, line 56)						0
61.00	Equipment cost (see instructions)						0
62.00	Supplies (see instructions)						0
63.00	Total allowance (sum of lines 57-62)						56,051
64.00	Total cost of outside supplier services (from your records)						51,258
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						9,655
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,421
100.02	Line 33 = line 28 = sum of lines 26 and 27						11,076
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,421
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
101.02	Line 34 = sum of lines 27 and 31						1,421
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0
102.02	Line 35 = sum of lines 31 and 32						0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,524,706	1,524,706			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	860,618		860,618		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,176,455	4,669	304	4,181,428	4.00
5.01	00570	ADMITTING	494,815	8,889	1,731	153,843	659,278 5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	844,153	39,523	4,836	167,879	0 5.02
5.03	00590	OTHER ADMIN & GENERAL	3,472,526	370,984	187,921	513,169	0 5.03
7.00	00700	OPERATION OF PLANT	1,207,005	132,322	6,298	115,585	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,644	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	453,281	8,829	1,713	126,898	0 9.00
10.00	01000	DIETARY	142,579	33,686	2,168	21,287	0 10.00
11.00	01100	CAFETERIA	386,335	21,430	0	72,806	0 11.00
13.00	01300	NURSING ADMINISTRATION	339,697	19,934	1,614	104,755	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	172,596	21,101	1,087	49,655	0 14.00
15.00	01500	PHARMACY	396,483	26,279	29,638	80,843	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	596,951	21,191	4,876	161,288	0 16.00
17.00	01700	SOCIAL SERVICE	256,947	2,290	0	76,201	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,806,583	149,068	46,935	548,644	29,065 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,337,546	113,406	202,064	275,631	58,324 50.00
53.00	05300	ANESTHESIOLOGY	4,186	0	23,259	0	8,555 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,754	75,559	264,601	255,926	194,983 54.00
60.00	06000	LABORATORY	1,821,048	27,760	25,350	289,308	121,277 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,230	3,232	832	1,604	674 62.00
64.00	06400	INTRAVENOUS THERAPY	222,234	16,611	8,693	70,025	5,625 64.00
65.00	06500	RESPIRATORY THERAPY	928,389	54,952	418	12,091	16,366 65.00
66.00	06600	PHYSICAL THERAPY	664,567	37,473	1,316	46,249	25,154 66.00
67.00	06700	OCCUPATIONAL THERAPY	104,957	5,298	186	6,549	3,562 67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,570	0	0	0	3,509 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,721	0	0	0	2,953 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,091,983	0	0	0	114,835 73.00
76.00	03950	DIABETIC SERVICES	28,155	1,975	0	8,909	318 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,823,493	89,476	15,966	437,428	74,078 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,326,207	1,285,937	831,806	3,596,573	659,278 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,929	0	0	0 190.00
194.00	07950	OCCUPATIONAL HEALTH	405,780	0	789	93,392	0 194.00
194.01	07951	FOUNDATION	0	0	0	0	0 194.01
194.02	07952	PHYSICIANS CLINICS	0	58,065	8,916	0	0 194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,715,020	173,775	19,107	491,463	0 194.03
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	29,447,007	1,524,706	860,618	4,181,428	659,278 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description			CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,056,391					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	4,544,600	4,544,600			5.03
7.00	00700	OPERATION OF PLANT	0	1,461,210	266,665	1,727,875		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,644	12,345	0	79,989	8.00
9.00	00900	HOUSEKEEPING	0	590,721	107,804	15,755	0	9.00
10.00	01000	DIETARY	0	199,720	36,448	60,110	0	10.00
11.00	01100	CAFETERIA	0	480,571	87,702	38,240	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	466,000	85,043	35,570	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	244,439	44,609	37,652	0	14.00
15.00	01500	PHARMACY	0	533,243	97,315	46,892	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	784,306	143,133	37,813	0	16.00
17.00	01700	SOCIAL SERVICE	0	335,438	61,216	4,086	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,095	2,626,390	479,306	265,997	19,415	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	92,499	2,079,470	379,495	202,362	12,178	50.00
53.00	05300	ANESTHESIOLOGY	13,569	49,569	9,046	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,181	3,050,004	556,623	134,828	17,961	54.00
60.00	06000	LABORATORY	192,339	2,477,082	452,058	49,536	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,069	53,641	9,789	5,768	0	62.00
64.00	06400	INTRAVENOUS THERAPY	8,921	332,109	60,609	29,641	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,955	1,038,171	189,462	98,057	0	65.00
66.00	06600	PHYSICAL THERAPY	39,893	814,652	148,671	66,867	3,907	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,649	126,201	23,031	9,453	554	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,566	23,645	4,315	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,683	97,357	17,767	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,122	1,388,940	253,476	0	0	73.00
76.00	03950	DIABETIC SERVICES	504	39,861	7,274	3,525	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	117,483	2,557,924	466,811	159,663	25,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,045,528	26,462,908	4,000,013	1,301,815	79,989	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,929	1,265	12,364	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	499,961	91,241	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	10,863	77,844	14,206	103,611	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,399,365	437,875	310,085	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,056,391	29,447,007	4,544,600	1,727,875	79,989	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1312

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	714,280					9.00
10.00	01000	DIETARY	25,078	321,356				10.00
11.00	01100	CAFETERIA	15,953	0	622,466			11.00
13.00	01300	NURSING ADMINISTRATION	14,839	0	8,653	610,105		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,708	0	8,970	0	351,378	14.00
15.00	01500	PHARMACY	19,563	0	10,236	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,775	0	34,155	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,705	0	8,126	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	110,972	244,056	173,310	296,662	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	84,424	27,651	42,984	73,592	24,596	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,249	0	59,834	0	3,514	54.00
60.00	06000	LABORATORY	20,666	0	80,869	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,406	0	457	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	12,366	14,463	9,673	16,570	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,908	0	1,653	2,854	0	65.00
66.00	06600	PHYSICAL THERAPY	27,896	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,944	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	175,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	147,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	1,471	0	1,372	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	66,610	35,186	128,567	220,427	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	536,533	321,356	568,859	610,105	351,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,158	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	43,226	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	129,363	0	53,607	0	0	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)	714,280	321,356	622,466	610,105	351,378	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	707,249					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,015,182				16.00
17.00	01700	SOCIAL SERVICE	0	0	410,571			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6	175,497	410,571	4,802,182	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	53,822	0	2,980,574	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	58,615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,064	67,638	0	3,982,715	0	54.00
60.00	06000	LABORATORY	0	140,680	0	3,220,891	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	72,061	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	142,842	0	618,273	0	64.00
65.00	06500	RESPIRATORY THERAPY	3	6,177	0	1,377,285	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,404	0	1,090,397	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,025	0	167,208	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	203,649	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	262,703	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,176	0	0	2,313,592	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	53,503	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	396,097	0	4,057,259	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	707,249	1,015,182	410,571	25,260,907	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	25,716	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	591,202	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	238,887	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	3,330,295	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	707,249	1,015,182	410,571	29,447,007	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00570	ADMITTING	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.02
5.03	00590	OTHER ADMIN & GENERAL	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OCCUPATIONAL HEALTH	194.00
194.01	07951	FOUNDATION	194.01
194.02	07952	PHYSICIANS CLINICS	194.02
194.03	07953	HEALTH & WELLNESS CENTER	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,669	304	4,973	4.00
5.01	00570	ADMITTING	0	8,889	1,731	10,620	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	39,523	4,836	44,359	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	370,984	187,921	558,905	5.03
7.00	00700	OPERATION OF PLANT	0	132,322	6,298	138,620	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,829	1,713	10,542	9.00
10.00	01000	DIETARY	0	33,686	2,168	35,854	10.00
11.00	01100	CAFETERIA	0	21,430	0	21,430	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,934	1,614	21,548	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,101	1,087	22,188	14.00
15.00	01500	PHARMACY	0	26,279	29,638	55,917	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,191	4,876	26,067	16.00
17.00	01700	SOCIAL SERVICE	0	2,290	0	2,290	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	149,068	46,935	196,003	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	113,406	202,064	315,470	50.00
53.00	05300	ANESTHESIOLOGY	0	0	23,259	23,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,559	264,601	340,160	54.00
60.00	06000	LABORATORY	0	27,760	25,350	53,110	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,232	832	4,064	62.00
64.00	06400	INTRAVENOUS THERAPY	0	16,611	8,693	25,304	64.00
65.00	06500	RESPIRATORY THERAPY	0	54,952	418	55,370	65.00
66.00	06600	PHYSICAL THERAPY	0	37,473	1,316	38,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,298	186	5,484	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	1,975	0	1,975	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	89,476	15,966	105,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,285,937	831,806	2,117,743	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,929	0	6,929	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	789	789	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	58,065	8,916	66,981	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	173,775	19,107	192,882	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,524,706	860,618	2,385,324	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	10,803					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	44,558				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	559,515			5.03
7.00	00700	OPERATION OF PLANT	0	0	32,830	171,587		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,520	0	1,520	8.00
9.00	00900	HOUSEKEEPING	0	0	13,272	1,565	0	9.00
10.00	01000	DIETARY	0	0	4,487	5,969	0	10.00
11.00	01100	CAFETERIA	0	0	10,797	3,797	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	10,470	3,532	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	5,492	3,739	0	14.00
15.00	01500	PHARMACY	0	0	11,981	4,657	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	17,622	3,755	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	7,537	406	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	476	1,943	59,010	26,415	369	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	955	3,900	46,722	20,096	231	50.00
53.00	05300	ANESTHESIOLOGY	140	572	1,114	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,205	13,057	68,535	13,389	341	54.00
60.00	06000	LABORATORY	1,985	8,109	55,655	4,919	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11	45	1,205	573	0	62.00
64.00	06400	INTRAVENOUS THERAPY	92	376	7,462	2,944	0	64.00
65.00	06500	RESPIRATORY THERAPY	268	1,094	23,326	9,738	0	65.00
66.00	06600	PHYSICAL THERAPY	412	1,682	18,304	6,640	74	66.00
67.00	06700	OCCUPATIONAL THERAPY	58	238	2,835	939	11	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57	235	531	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48	197	2,187	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,879	7,678	31,207	0	0	73.00
76.00	03950	DIABETIC SERVICES	5	21	896	350	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,212	4,953	57,471	15,855	494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,803	44,100	492,468	129,278	1,520	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	156	1,228	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	11,233	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	458	1,749	10,289	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	53,909	30,792	0	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)	10,803	44,558	559,515	171,587	1,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	25,530					9.00
10.00	01000	DIETARY	896	47,231				10.00
11.00	01100	CAFETERIA	570	0	36,680			11.00
13.00	01300	NURSING ADMINISTRATION	530	0	510	36,714		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	561	0	529	0	32,568	14.00
15.00	01500	PHARMACY	699	0	603	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	564	0	2,013	0	0	16.00
17.00	01700	SOCIAL SERVICE	61	0	479	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,966	35,870	10,212	17,851	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,017	4,064	2,533	4,429	2,280	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,010	0	3,526	0	326	54.00
60.00	06000	LABORATORY	739	0	4,765	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	86	0	27	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	442	2,126	570	997	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,462	0	97	172	0	65.00
66.00	06600	PHYSICAL THERAPY	997	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	141	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	53	0	81	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,381	5,171	7,576	13,265	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,175	47,231	33,521	36,714	32,568	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	184	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	1,545	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	4,626	0	3,159	0	0	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)	25,530	47,231	36,680	36,714	32,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	73,953					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,213				16.00
17.00	01700	SOCIAL SERVICE	0	0	10,864			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1	8,680	10,864	372,317	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,662	0	406,686	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	25,085	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,771	3,345	0	451,969	0	54.00
60.00	06000	LABORATORY	0	6,958	0	136,584	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,013	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,065	0	47,461	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	306	0	91,847	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,405	0	68,358	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	199	0	9,913	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,106	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,111	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,181	0	0	110,945	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	3,392	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	19,593	0	233,933	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,953	50,213	10,864	1,997,720	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,497	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	12,133	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	81,022	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	285,952	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	73,953	50,213	10,864	2,385,324	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00570	ADMITTING	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.02
5.03	00590	OTHER ADMIN & GENERAL	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OCCUPATIONAL HEALTH	194.00
194.01	07951	FOUNDATION	194.01
194.02	07952	PHYSICIANS CLINICS	194.02
194.03	07953	HEALTH & WELLNESS CENTER	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	101,884					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		840,185				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312	297	12,542,395			4.00
5.01	00570	ADMITTING	594	1,690	461,460	57,698,569		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,641	4,721	503,560	0	58,298,063	5.02
5.03	00590	OTHER ADMIN & GENERAL	24,790	183,459	1,539,273	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	6,148	346,701	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	1,672	380,636	0	0	9.00
10.00	01000	DIETARY	2,251	2,117	63,850	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	218,385	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,332	1,576	314,217	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,410	1,061	148,943	0	0	14.00
15.00	01500	PHARMACY	1,756	28,934	242,491	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	4,760	483,791	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	228,567	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,961	45,821	1,645,703	2,543,740	2,543,740	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,578	197,266	826,768	5,104,526	5,104,526	50.00
53.00	05300	ANESTHESIOLOGY	0	22,707	0	748,773	748,773	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	258,320	767,660	17,063,634	17,063,634	54.00
60.00	06000	LABORATORY	1,855	24,748	867,791	10,614,140	10,614,140	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	216	812	4,812	58,981	58,981	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	8,487	210,044	492,314	492,314	64.00
65.00	06500	RESPIRATORY THERAPY	3,672	408	36,267	1,432,305	1,432,305	65.00
66.00	06600	PHYSICAL THERAPY	2,504	1,285	138,725	2,201,496	2,201,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	354	182	19,644	311,735	311,735	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	307,134	307,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	258,447	258,447	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,050,307	10,050,307	73.00
76.00	03950	DIABETIC SERVICES	132	0	26,724	27,793	27,793	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,979	15,587	1,312,086	6,483,244	6,483,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,929	812,058	10,788,098	57,698,569	57,698,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	770	280,132	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,880	8,704	0	0	599,494	194.02
194.03	07953	HEALTH & WELLNESS CENTER	11,612	18,653	1,474,165	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)	1,524,706	860,618	4,181,428	659,278	1,056,391	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.965117	1.024320	0.333384	0.011426	0.018121	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,973	10,803	44,558	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000396	0.000187	0.000764	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.03	5.03	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL	-4,544,600	24,902,407			5.03
7.00	00700	OPERATION OF PLANT	0	1,461,210	64,705		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,644	0	87,565	8.00
9.00	00900	HOUSEKEEPING	0	590,721	590	0	9.00
10.00	01000	DIETARY	0	199,720	2,251	0	10.00
11.00	01100	CAFETERIA	0	480,571	1,432	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	466,000	1,332	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	244,439	1,410	0	14.00
15.00	01500	PHARMACY	0	533,243	1,756	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	784,306	1,416	0	16.00
17.00	01700	SOCIAL SERVICE	0	335,438	153	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,626,390	9,961	21,254	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,079,470	7,578	13,331	50.00
53.00	05300	ANESTHESIOLOGY	0	49,569	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,050,004	5,049	19,662	54.00
60.00	06000	LABORATORY	0	2,477,082	1,855	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	53,641	216	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	332,109	1,110	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,038,171	3,672	0	65.00
66.00	06600	PHYSICAL THERAPY	0	814,652	2,504	4,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	126,201	354	606	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,645	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	97,357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,388,940	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	39,861	132	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,557,924	5,979	28,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,544,600	21,918,308	48,750	87,565	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,929	463	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	499,961	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	77,844	3,880	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,399,365	11,612	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)		4,544,600	1,727,875	79,989	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.182496	26.703887	0.913481	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		559,515	171,587	1,520	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.022468	2.651835	0.017359	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	5,288					10.00
11.00	01100	CAFETERIA	0	17,696				11.00
13.00	01300	NURSING ADMINISTRATION	0	246	210,757			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	255	0	100		14.00
15.00	01500	PHARMACY	0	291	0	0	1,091,983	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	971	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	231	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,016	4,927	102,480	0	10	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	455	1,222	25,422	7	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,701	0	1	55,683	54.00
60.00	06000	LABORATORY	0	2,299	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	13	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	238	275	5,724	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	47	986	0	4	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,036,286	73.00
76.00	03950	DIABETIC SERVICES	0	39	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	579	3,655	76,145	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,288	16,172	210,757	100	1,091,983	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,524	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)	321,356	622,466	610,105	351,378	707,249	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	60.770802	35.175520	2.894827	3,513.780000	0.647674	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,231	36,680	36,714	32,568	73,953	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.931732	2.072785	0.174201	325.680000	0.067724	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00590	OTHER ADMIN & GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,610	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	17,047	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,228	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,570	54.00
60.00	06000	LABORATORY	13,665	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
64.00	06400	INTRAVENOUS THERAPY	13,875	64.00
65.00	06500	RESPIRATORY THERAPY	600	65.00
66.00	06600	PHYSICAL THERAPY	2,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	391	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	DIABETIC SERVICES	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	38,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,610	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	194.00
194.01	07951	FOUNDATION	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	194.03
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)	1,015,182	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.294919	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,213	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.509208	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2020 8:14 am

				Title XVIII	Hospital	Cost			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,802,182		4,802,182	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,980,574		2,980,574	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	58,615		58,615	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,982,715		3,982,715	0	0	54.00	
60.00	06000	LABORATORY	3,220,891		3,220,891	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	72,061		72,061	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	618,273		618,273	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1,377,285	0	1,377,285	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,090,397	0	1,090,397	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	167,208	0	167,208	0	0	67.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,649		203,649	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	262,703		262,703	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,313,592		2,313,592	0	0	73.00	
76.00	03950	DIABETIC SERVICES	53,503		53,503	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	4,057,259		4,057,259	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,622,177		1,622,177		0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	26,883,084	0	26,883,084	0	0	200.00	
201.00		Less Observation Beds	1,622,177		1,622,177		0	201.00	
202.00		Total (see instructions)	25,260,907	0	25,260,907	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2020 8:14 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,209,700		1,209,700		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	481,516	4,623,010	5,104,526	0.583908	50.00
53.00	05300	ANESTHESIOLOGY	57,042	691,731	748,773	0.078281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	439,791	16,623,843	17,063,634	0.233404	54.00
60.00	06000	LABORATORY	474,576	10,139,564	10,614,140	0.303453	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,272	36,709	58,981	1.221766	62.00
64.00	06400	INTRAVENOUS THERAPY	90	492,224	492,314	1.255851	64.00
65.00	06500	RESPIRATORY THERAPY	239,550	1,192,755	1,432,305	0.961586	65.00
66.00	06600	PHYSICAL THERAPY	104,976	2,096,520	2,201,496	0.495298	66.00
67.00	06700	OCCUPATIONAL THERAPY	640	311,095	311,735	0.536379	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	175,026	132,108	307,134	0.663062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	106,695	151,752	258,447	1.016468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	924,067	9,126,240	10,050,307	0.230201	73.00
76.00	03950	DIABETIC SERVICES	0	27,793	27,793	1.925053	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	6,483,244	6,483,244	0.625807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	540	1,333,500	1,334,040	1.215988	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,236,481	53,462,088	57,698,569		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,236,481	53,462,088	57,698,569		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2020 8:14 am

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	406,686	5,104,526	0.079672	198,000	15,775
53.00	05300	ANESTHESIOLOGY	25,085	748,773	0.033501	23,501	787
54.00	05400	RADIOLOGY-DIAGNOSTIC	451,969	17,063,634	0.026487	312,756	8,284
60.00	06000	LABORATORY	136,584	10,614,140	0.012868	287,366	3,698
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,013	58,981	0.101948	15,270	1,557
64.00	06400	INTRAVENOUS THERAPY	47,461	492,314	0.096404	0	0
65.00	06500	RESPIRATORY THERAPY	91,847	1,432,305	0.064125	143,410	9,196
66.00	06600	PHYSICAL THERAPY	68,358	2,201,496	0.031051	41,975	1,303
67.00	06700	OCCUPATIONAL THERAPY	9,913	311,735	0.031799	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,106	307,134	0.055696	98,050	5,461
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,111	258,447	0.062338	68,394	4,264
73.00	07300	DRUGS CHARGED TO PATIENTS	110,945	10,050,307	0.011039	498,321	5,501
76.00	03950	DIABETIC SERVICES	3,392	27,793	0.122045	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	233,933	6,483,244	0.036083	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	125,769	1,334,040	0.094277	90	8
200.00		Total (lines 50 through 199)	1,751,172	56,488,869		1,687,133	55,834

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1312		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/24/2020 8:14 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description			Title XVIII		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,104,526	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	748,773	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,063,634	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,614,140	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	58,981	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	492,314	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,432,305	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,201,496	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	311,735	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	307,134	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	258,447	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,050,307	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	27,793	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,483,244	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,334,040	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	56,488,869		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/24/2020 8:14 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	198,000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,501	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	312,756	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	287,366	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	15,270	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	143,410	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,975	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	98,050	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	68,394	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	498,321	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	90	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,687,133	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/24/2020 8:14 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
					Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.583908	0	1,673,693	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.078281	0	265,270	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233404	0	5,351,666	0	0	54.00
60.00	06000	LABORATORY	0.303453	0	3,629,575	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.221766	0	19,482	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.255851	0	194,697	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.961586	0	489,129	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.495298	0	634,714	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.536379	0	76,839	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663062	0	57,271	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.016468	0	48,637	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230201	0	4,380,939	0	0	73.00
76.00	03950	DIABETIC SERVICES	1.925053	0	10,742	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.625807	0	1,847,794	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.215988	0	579,456	0	0	92.00
200.00		Subtotal (see instructions)		0	19,259,904	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	19,259,904	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/24/2020 8:14 am

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	977,283	0		50.00
53.00	05300	ANESTHESIOLOGY	20,766	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,249,100	0		54.00
60.00	06000	LABORATORY	1,101,405	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23,802	0		62.00
64.00	06400	INTRAVENOUS THERAPY	244,510	0		64.00
65.00	06500	RESPIRATORY THERAPY	470,340	0		65.00
66.00	06600	PHYSICAL THERAPY	314,373	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	41,215	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,974	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,438	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,008,497	0		73.00
76.00	03950	DIABETIC SERVICES	20,679	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,156,362	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	704,612	0		92.00
200.00		Subtotal (see instructions)	7,420,356	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,420,356	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/24/2020 8:14 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,418	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,291	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)		812	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)		127	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) (see instructions)		476	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)		127	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,802,182	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)		430,097	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,372,085	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,372,085	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)		3,386.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,612,017	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,612,017	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/24/2020 8:14 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					704,358 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,316,375 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)					430,097 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					430,097 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)					479 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,386.59 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,622,177 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	372,317	4,802,182	0.077531	1,622,177	125,769	90.00
91.00	Nursing School cost	0	4,802,182	0.000000	1,622,177	0	91.00
92.00	Allied health cost	0	4,802,182	0.000000	1,622,177	0	92.00
93.00	All other Medical Education	0	4,802,182	0.000000	1,622,177	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/24/2020 8:14 am	
Cost Center Description			Title XVIII	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		620,500		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.583908	198,000	115,614	50.00
53.00	05300	ANESTHESIOLOGY	0.078281	23,501	1,840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233404	312,756	72,999	54.00
60.00	06000	LABORATORY	0.303453	287,366	87,202	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.221766	15,270	18,656	62.00
64.00	06400	INTRAVENOUS THERAPY	1.255851	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.961586	143,410	137,901	65.00
66.00	06600	PHYSICAL THERAPY	0.495298	41,975	20,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.536379	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663062	98,050	65,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.016468	68,394	69,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230201	498,321	114,714	73.00
76.00	03950	DIABETIC SERVICES	1.925053	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.625807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.215988	90	109	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,687,133	704,358	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,687,133		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1312 Component CCN: 14-Z312	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/24/2020 8:14 am	
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.583908	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.078281	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233404	3,996	933	54.00
60.00	06000	LABORATORY	0.303453	23,043	6,992	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.221766	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.255851	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.961586	22,925	22,044	65.00
66.00	06600	PHYSICAL THERAPY	0.495298	47,738	23,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.536379	640	343	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663062	25,194	16,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.016468	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230201	60,174	13,852	73.00
76.00	03950	DIABETIC SERVICES	1.925053	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.625807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.215988	450	547	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		184,160	85,061	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		184,160		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/24/2020 8:14 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,420,356 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,420,356 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			7,494,560 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			34,345 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,192,061 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			4,268,154 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,268,154 30.00
31.00	Primary payer payments			372 31.00
32.00	Subtotal (line 30 minus line 31)			4,267,782 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			790,151 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			513,598 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			4,781,380 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,781,380 40.00
40.01	Sequestration adjustment (see instructions)			95,628 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			4,349,614 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			336,138 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
9/24/2020 8:14 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,707,176		4,089,414	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02		10/30/2019	61,700	10/30/2019	260,200	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		61,700		260,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,768,876		4,349,614	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		366,849		336,138	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,135,725		4,685,752	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1312

Period:

Worksheet E-1

Component CCN: 14-Z312

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/24/2020 8:14 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		396,990		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		396,990		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		111,577		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		508,567		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part II
Date/Time Prepared:
9/24/2020 8:14 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1312

Period:

Worksheet E-2

Component CCN: 14-Z312

From 05/01/2019

Date/Time Prepared:

To 04/30/2020

9/24/2020 8:14 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		434,398	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		85,912	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		127	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		520,310	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		520,310	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		520,310	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,364	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		518,946	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		518,946	0	19.00
19.01	Sequestration adjustment (see instructions)		10,379	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		396,990	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		111,577	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1312	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part V Date/Time Prepared: 9/24/2020 8:14 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,316,375	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,316,375	4.00
5.00	Primary payer payments		5,225	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,334,314	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,334,314	19.00
20.00	Deductibles (exclude professional component)		184,404	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,149,910	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,149,910	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		45,232	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		29,401	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		45,232	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,179,311	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,179,311	30.00
30.01	Sequestration adjustment (see instructions)		43,586	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,768,876	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		366,849	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet G

Date/Time Prepared:

9/24/2020 8:14 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	14,732,569	0	0	0	1.00
2.00	Temporary investments	12,393,274	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,531,727	0	0	0	4.00
5.00	Other receivable	340,679	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	373,349	0	0	0	7.00
8.00	Prepaid expenses	809,680	0	0	0	8.00
9.00	Other current assets	294,000	0	0	0	9.00
10.00	Due from other funds	56,008	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	32,531,286	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,684,161	0	0	0	12.00
13.00	Land improvements	1,463,837	0	0	0	13.00
14.00	Accumulated depreciation	-1,119,258	0	0	0	14.00
15.00	Buildings	22,331,507	0	0	0	15.00
16.00	Accumulated depreciation	-11,568,951	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,735,594	0	0	0	19.00
20.00	Accumulated depreciation	-1,970,539	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,552,208	0	0	0	23.00
24.00	Accumulated depreciation	-7,067,880	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	3,464,930	0	0	0	27.00
28.00	Accumulated depreciation	-3,464,930	0	0	0	28.00
29.00	Minor equipment-nondepreciable	125,947	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,166,626	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	60,898	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	60,898	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,758,810	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	806,137	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,812,389	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	525,036	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	214,262	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,357,824	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,974,756	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	55,986	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,030,742	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,388,566	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	42,370,244				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)	42,370,244	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,758,810	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-1

Date/Time Prepared:
9/24/2020 8:14 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		40,957,455		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,412,789				2.00
3.00	Total (sum of line 1 and line 2)		42,370,244		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)		42,370,244		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)		42,370,244		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/24/2020 8:14 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,043,320		1,043,320	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	163,380		163,380	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				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,206,700		1,206,700	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,000		3,000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,000		3,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,209,700		1,209,700	17.00
18.00	Ancillary services	3,026,241	45,617,551	48,643,792	18.00
19.00	Outpatient services	540	7,844,537	7,845,077	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL PHYSICIAN CHARGES	842,838	2,153,623	2,996,461	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,079,319	55,615,711	60,695,030	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,396,878		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,396,878		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1312

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-3

Date/Time Prepared:
9/24/2020 8:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,695,030	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,742,137	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,952,893	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,396,878	4.00
5.00	Net income from service to patients (line 3 minus line 4)	556,015	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	39,660	6.00
7.00	Income from investments	-193,180	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	101,324	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,322	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	62,204	22.00
23.00	Governmental appropriations	684,890	23.00
24.00	MISCELLANEOUS INCOME	157,554	24.00
25.00	Total other income (sum of lines 6-24)	856,774	25.00
26.00	Total (line 5 plus line 25)	1,412,789	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,412,789	29.00