

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).

OMB NO. 0938-0050
EXPIRES 03-31-2022

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

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet S
Parts I-III
Date/Time Prepared:
11/28/2020 3:01 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/28/2020	Time: 3:01 pm
	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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. FRANCIS HOSPITAL (14-1350) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-349,927	880,477	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	62,157	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-287,770	880,477	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 3:01 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1215 FRANCISCAN DRIVE			PO Box:				1.00	
2.00	City: LITCHFIELD			State: IL		Zip Code: 62056		County: MONTGOMERY	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ST. FRANCIS HOSPITAL	141350	99914	1	12/01/2005	N
4.00	Subprovider - IPF							0	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			ST. FRANCIS HOSPITAL	142350	99914		05/31/2007	N
8.00	Swing Beds - NF							0	0
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						1		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 3:01 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no 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			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 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: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

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

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

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

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						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
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				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	48,016	11,300	361,122	118.01		
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N N				120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	

MCRIF32 - 16.4.169.5

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 3:01 pm
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 11/28/2020 3:01 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/15/2020	Y	10/15/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/28/2020 3:01 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/28/2020 3:01 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	77,058.18	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	77,058.18	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	77,058.18	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,941	60	3,180		1.00
2.00	HMO and other (see instructions)	268	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	414	0	489		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	33		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,355	60	3,702		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		90	314		13.00
14.00	Total (see instructions)	2,355	150	4,016	0.00	200.57
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			5		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC					25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	26.25
28.00	Observation Bed Days		11	646		27.00
29.00	Ambulance Trips	0				28.00
30.00	Employee discount days (see instruction)			21		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	597	21	1,131	1.00
2.00 HMO and other (see instructions)			90	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	597	21	1,131	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/28/2020 3:01 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.283815 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	7,086,421		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?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	33,138,220		6.00
7.00	Medicaid cost (line 1 times line 6)	9,405,124		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)	2,318,703		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,318,703		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,421,458	867,978	3,289,436 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	687,246	867,978	1,555,224 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	687,246	867,978	1,555,224 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,504,998		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,268,994		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,952,298		27.01
28.00	Non-Medicare bad debt expense (see instructions)	552,700		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	840,169		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,395,393		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,714,096		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		458,987	458,987	1,203,508	1,662,495 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,674,451	2,674,451	-1,160,372	1,514,079 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,948	4,402,580	4,463,528	836,949	5,300,477 4.00
5.01	00570	ADMITTING	0	0	0	93	93 5.01
5.02	00540	PATIENT ACCOUNTING	0	0	0	0	0 5.02
5.03	00550	ADMINISTRATIVE & GENERAL	2,265,252	12,594,094	14,859,346	-1,200,918	13,658,428 5.03
6.00	00600	MAINTENANCE & REPAIRS	280,178	32,858	313,036	0	313,036 6.00
7.00	00700	OPERATION OF PLANT	88,091	1,132,642	1,220,733	29,051	1,249,784 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-296	-296	135,715	135,419 8.00
9.00	00900	HOUSEKEEPING	298,054	257,694	555,748	0	555,748 9.00
10.00	01000	DIETARY	319,133	220,579	539,712	-374,962	164,750 10.00
11.00	01100	CAFETERIA	0	0	0	375,759	375,759 11.00
13.00	01300	NURSING ADMINISTRATION	521,612	72,053	593,665	341	594,006 13.00
15.00	01500	PHARMACY	567,090	3,934,011	4,501,101	-3,694,387	806,714 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,986	1,986	0	1,986 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,033,339	325,247	3,358,586	-1,182,917	2,175,669 30.00
43.00	04300	NURSERY	0	0	0	131,372	131,372 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,187,838	1,784,031	2,971,869	-614,356	2,357,513 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	793,500	793,500 52.00
53.00	05300	ANESTHESIOLOGY	0	1,014,295	1,014,295	-25,122	989,173 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	837,911	300,592	1,138,503	-22,240	1,116,263 54.00
57.00	05700	CT SCAN	89,937	230,174	320,111	1,084	321,195 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	89,611	134,322	223,933	6,162	230,095 58.00
60.00	06000	LABORATORY	633,773	858,705	1,492,478	228,794	1,721,272 60.00
65.00	06500	RESPIRATORY THERAPY	470,464	231,975	702,439	42,430	744,869 65.00
66.00	06600	PHYSICAL THERAPY	241,003	880,932	1,121,935	1,266	1,123,201 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	107,566	107,566	179,579	287,145 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	604,476	604,476 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,816,367	3,816,367 73.00
76.00	03020	OTHER	0	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	145,553	10,980	156,533	579	157,112 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	297,912	1,224,855	1,522,767	-1,506	1,521,261 90.00
91.00	09100	EMERGENCY	1,288,285	1,831,734	3,120,019	-77,020	3,042,999 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,715,984	34,717,047	47,433,031	33,225	47,466,256 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,056	37,056	0	37,056 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	147,945	87,755	235,700	-33,225	202,475 192.00
194.00	07950	OTHER NONALLOWABLE	160,597	104,095	264,692	0	264,692 194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	13,024,526	34,945,953	47,970,479	0	47,970,479 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	20,214	1,682,709	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-574,783	939,296	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-819,558	4,480,919	4.00
5.01	00570	ADMITTING	328,969	329,062	5.01
5.02	00540	PATIENT ACCOUNTING	761,096	761,096	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-6,643,204	7,015,224	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	313,036	6.00
7.00	00700	OPERATION OF PLANT	-7,128	1,242,656	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,194	181,613	8.00
9.00	00900	HOUSEKEEPING	382	556,130	9.00
10.00	01000	DIETARY	0	164,750	10.00
11.00	01100	CAFETERIA	0	375,759	11.00
13.00	01300	NURSING ADMINISTRATION	-559	593,447	13.00
15.00	01500	PHARMACY	0	806,714	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	695,038	697,024	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-34,943	2,140,726	30.00
43.00	04300	NURSERY	0	131,372	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,357,513	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	793,500	52.00
53.00	05300	ANESTHESIOLOGY	-962,143	27,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-189	1,116,074	54.00
57.00	05700	CT SCAN	0	321,195	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	230,095	58.00
60.00	06000	LABORATORY	-40,226	1,681,046	60.00
65.00	06500	RESPIRATORY THERAPY	-116,370	628,499	65.00
66.00	06600	PHYSICAL THERAPY	-61,094	1,062,107	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	287,145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	604,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,816,367	73.00
76.00	03020	OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	157,112	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,057,615	463,646	90.00
91.00	09100	EMERGENCY	-828,407	2,214,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,294,326	38,171,930	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,056	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	202,475	192.00
194.00	07950	OTHER NONALLOWABLE	0	264,692	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,294,326	38,676,153	200.00

RECLASSIFICATIONS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
11/28/2020 3:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - L&D AND NURSERY SAL & OTHER EXP					
1.00	NURSERY	43.00	116,763	14,614		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	708,047	88,620		2.00
	0		824,810	103,234		
	B - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,769,682		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	3,769,682		
	C - CAFETERIA SALARIES & OTHER COSTS					
1.00	CAFETERIA	11.00	222,187	153,572		1.00
	0		222,187	153,572		
	D - LAUNDRY COSTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	135,715		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	135,715		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	231,902		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	529,665		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	761,567		
	F - LAB ADMINISTRATION COSTS					
1.00	LABORATORY	60.00	187,195	19,212		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		187,195	19,212		
	H - SHARED SERVICES COSTS					
1.00	ADULTS & PEDIATRICS	30.00	16,007	0		1.00
2.00	LABORATORY	60.00	13,227	0		2.00
3.00	RESPIRATORY THERAPY	65.00	43,672	0		3.00
	0		72,906	0		
	I - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,989		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,147		2.00
	0		0	43,136		
	J - RADIOLOGY MANAGERS COST					
1.00	CT SCAN	57.00	7,585	0		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,521	0		2.00
	0		13,106	0		
	O - SEGREGATE DIRECT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	74,811		1.00
	0		0	74,811		
	P - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,168,519		1.00
	0		0	1,168,519		

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6
Date/Time Prepared:
11/28/2020 3:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	Q - MOB UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	28,973	1.00	
	0		0	28,973		
	R - COVID EXPENSES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	845,782	1.00	
2.00	ADMITTING	5.01	93	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	78	3.00	
4.00	DIETARY	10.00	898	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	341	0	5.00	
6.00	ADULTS & PEDIATRICS	30.00	21,745	0	6.00	
7.00	OPERATING ROOM	50.00	66,313	0	7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	3,339	0	8.00	
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	2,469	0	9.00	
10.00	LABORATORY	60.00	3,441	8,800	10.00	
11.00	RESPIRATORY THERAPY	65.00	1,192	0	11.00	
12.00	PHYSICAL THERAPY	66.00	1,485	0	12.00	
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,490	13.00	
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	46,685	14.00	
15.00	CARDIAC REHABILITATION	76.97	579	0	15.00	
16.00	EMERGENCY	91.00	3,913	0	16.00	
	TOTALS		105,808	923,835		
500.00	Grand Total: Increases		1,426,012	7,182,256	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/28/2020 3:01 pm

Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - L&D AND NURSERY SAL & OTHER EXP							
1.00	ADULTS & PEDIATRICS	30.00	824,810	103,234	0		1.00
2.00		0.00	0	0	0		2.00
	0		824,810	103,234			
B - DRUG COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.03	0	64,066	0		1.00
2.00	DIETARY	10.00	0	101	0		2.00
3.00	PHARMACY	15.00	0	3,694,266	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,804	0		4.00
5.00	OPERATING ROOM	50.00	0	1,491	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	1,128	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	290	0		7.00
8.00	CT SCAN	57.00	0	2,965	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	192	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	51	0		10.00
11.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2	0		11.00
12.00	CLINIC	90.00	0	1,357	0		12.00
13.00	EMERGENCY	91.00	0	1,562	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	407	0		14.00
	0		0	3,769,682			
C - CAFETERIA SALARIES & OTHER COSTS							
1.00	DIETARY	10.00	222,187	153,572	0		1.00
	0		222,187	153,572			
D - LAUNDRY COSTS							
1.00	PHARMACY	15.00	0	121	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	70,027	0		2.00
3.00	NURSERY	43.00	0	5	0		3.00
4.00	OPERATING ROOM	50.00	0	16,774	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	30	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,183	0		6.00
7.00	CT SCAN	57.00	0	3,536	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,636	0		8.00
9.00	LABORATORY	60.00	0	3,081	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	2,434	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	168	0		11.00
12.00	CLINIC	90.00	0	149	0		12.00
13.00	EMERGENCY	91.00	0	21,726	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,845	0		14.00
	0		0	135,715			
E - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	34,352	0		1.00
2.00	OPERATING ROOM	50.00	0	662,404	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	23,994	0		3.00
4.00	EMERGENCY	91.00	0	40,817	0		4.00
	0		0	761,567			
F - LAB ADMINISTRATION COSTS							
1.00	ADULTS & PEDIATRICS	30.00	177,300	9,142	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,788	349	0		2.00
3.00	EMERGENCY	91.00	7,107	9,721	0		3.00
	0		187,195	19,212			
H - SHARED SERVICES COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.03	72,906	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		72,906	0			
I - BUILDING INSURANCE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,833	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.03	0	34,303	12		2.00
	0		0	43,136			
J - RADIOLOGY MANAGERS COST							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	13,106	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		13,106	0			
O - SEGREGATE DIRECT COSTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	74,811	0		1.00
	0		0	74,811			
P - DEPRECIATION EXPENSE RECLASS							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,168,519	9		1.00
	0		0	1,168,519			

RECLASSIFICATIONS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/28/2020 3:01 pm

	Decreases						11/26/2020 3:02 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	Q - MOB UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,973	0		1.00
	0		0	28,973			
	R - COVID EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.03	105,808	923,835	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	TOTALS		105,808	923,835			
500.00	Grand Total: Decreases		1,426,012	7,182,256			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	462,220	0	0	0	0	1.00
2.00	Land Improvements	1,911,747	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,926,818	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	29,078,778	3,858,919	0	3,858,919	1,071,426	5.00
6.00	Movable Equipment	24,600,524	935,128	0	935,128	373,034	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	67,980,087	4,794,047	0	4,794,047	1,444,460	8.00
9.00	Reconciling Items	0	1,616,749	0	1,616,749	0	9.00
10.00	Total (line 8 minus line 9)	67,980,087	3,177,298	0	3,177,298	1,444,460	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	462,220	0				1.00
2.00	Land Improvements	1,911,747	0				2.00
3.00	Buildings and Fixtures	11,926,818	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	31,866,271	0				5.00
6.00	Movable Equipment	25,162,618	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	71,329,674	0				8.00
9.00	Reconciling Items	1,616,749	0				9.00
10.00	Total (line 8 minus line 9)	69,712,925	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	423,998	0	0	34,989	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,666,304	0	0	8,147	0	2.00
3.00	Total (sum of lines 1-2)	3,090,302	0	0	43,136	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	458,987				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,674,451				2.00
3.00	Total (sum of lines 1-2)	0	3,133,438				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	46,167,056	0	46,167,056	0.647235	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,162,618	0	25,162,618	0.352765	0	2.00
3.00	Total (sum of lines 1-2)	71,329,674	0	71,329,674	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,071,718	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	923,002	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,994,720	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-458,987	69,978	0	0	1,682,709	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,294	0	0	939,296	2.00
3.00	Total (sum of lines 1-2)	-458,987	86,272	0	0	2,622,005	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-458,987	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,128	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,060,510			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	-160,826			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & 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	-104,619	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MARKETING SALARY	A	-80,029	ADMINISTRATIVE & GENERAL	5.03	0	33.00
33.01	MARKETING BENEFITS	A	-22,028	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MARKETING OTHER	A	-187,065	ADMINISTRATIVE & GENERAL	5.03	0	33.02
33.03	MISC INCOME	B	-404,297	ADMINISTRATIVE & GENERAL	5.03	0	33.03
33.04	BANK CHARGES	B	163	ADMINISTRATIVE & GENERAL	5.03	0	33.04
33.05	LAB MISC INCOME	B	-226	LABORATORY	60.00	0	33.05
33.06	ATHLETICARE	A	-56,651	PHYSICAL THERAPY	66.00	0	33.06
33.07	ATHLETICARE	A	-4,443	PHYSICAL THERAPY	66.00	0	33.07
33.08	ATHLETICARE	A	-15,596	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	AMBULANCE MISC INCOME	B	-670,128	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	ALCOHOL BEVERAGE COST	A	-3,029	ADMINISTRATIVE & GENERAL	5.03	0	33.10
33.11	ADVERTISING COST	A	-4,836	ADMINISTRATIVE & GENERAL	5.03	0	33.11
33.12	DEFINED PENSION ADJUSTMENT	A	639,416	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	FUND DEVELOPMENT - SALARY	A	-44,695	ADMINISTRATIVE & GENERAL	5.03	0	33.13
33.14	FUND DEVELOPMENT - OTHER	A	-102,814	ADMINISTRATIVE & GENERAL	5.03	0	33.14
33.15	SELF-INS TO HOSP/EMP CLIMS	A	-1,403,307	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	PHYSICIAN RECRUITMENT	A	-93,233	ADMINISTRATIVE & GENERAL	5.03	0	33.16
33.17	MEDICAID TAX ASSESSMENT	A	-1,356,521	ADMINISTRATIVE & GENERAL	5.03	0	33.17
33.18	LOBBYING EXPENSES	A	-15,804	ADMINISTRATIVE & GENERAL	5.03	0	33.18
33.19	MEALS TO NON-PROVIDERS	A	-25,010	ADMINISTRATIVE & GENERAL	5.03	0	33.19
33.20	CHARITABLE CONTRIBUTIONS	A	-9,110	ADMINISTRATIVE & GENERAL	5.03	0	33.20
33.21	NON-PATIENT TRAVEL	A	-16,374	ADMINISTRATIVE & GENERAL	5.03	0	33.21
33.22	NON-PATIENT TRAVEL	A	-513	ADULTS & PEDIATRICS	30.00	0	33.22
33.23	FUND DEVELOPMENT - BENEFITS	A	-12,305	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	ASSET RELIFING-BUILDING	A	479,201	CAP REL COSTS-BLDG & FIXT	1.00	9	33.24
33.25	ASSET RELIFING-EQUIPMENT	A	199,964	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.25
33.26	GIFTS	A	-4,844	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	GIFTS	A	-4,625	ADMINISTRATIVE & GENERAL	5.03	0	33.27
33.28	GIFTS	A	382	HOUSEKEEPING	9.00	0	33.28
33.29	GIFTS	A	-559	NURSING ADMINISTRATION	13.00	0	33.29
33.30	GIFTS	A	-189	RADIOLOGY-DIAGNOSTIC	54.00	0	33.30
33.31	MED GROUP PURCHASED SERVICES	A	-389,210	ADMINISTRATIVE & GENERAL	5.03	0	33.31
33.32	RESTRUCTURING	A	-1,893,941	ADMINISTRATIVE & GENERAL	5.03	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,294,326				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 3:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	3,498,627	3,499,521	1.00
2.00	5.03	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC	2,666,633	1,578,077	2.00
3.00	5.01	ADMITTING	SBO FEES - ADMITTING	328,969	0	3.00
3.01	5.02	PATIENT ACCOUNTING	SBO FEES - PATIENT ACCOUNTIN	761,096	0	3.01
3.02	5.03	ADMINISTRATIVE & GENERAL	SBO FEES - A&G	107,701	2,708,451	3.02
3.03	16.00	MEDICAL RECORDS & LIBRARY	SBO FEES - MEDICAL RECORDS	695,038	0	3.03
3.04	5.03	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - SSC	1,042,304	1,451,630	3.04
3.05	5.03	ADMINISTRATIVE & GENERAL	PURCHASED SERVICES	0	61,675	3.05
3.06	5.03	ADMINISTRATIVE & GENERAL	HSBS CID HOME OFFICE - OTHER	350,041	355,171	3.06
3.07	5.03	ADMINISTRATIVE & GENERAL	HSBS CID HOME OFFICE - LIBRA	13,359	16,263	3.07
3.08	8.00	LAUNDRY & LINEN SERVICE	HSBS CID HOME OFFICE - LAUND	180,592	134,398	3.08
3.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVCS	27,551	27,551	3.09
3.10	5.01	ADMITTING	RELATED PARTY SVCS	179	179	3.10
3.11	5.02	PATIENT ACCOUNTING	RELATED PARTY SVCS	21,567	21,567	3.11
3.12	5.03	ADMINISTRATIVE & GENERAL	RELATED PARTY SVCS	771,491	771,491	3.12
3.13	7.00	OPERATION OF PLANT	RELATED PARTY SVCS	1,209	1,209	3.13
3.14	9.00	HOUSEKEEPING	RELATED PARTY SVCS	123	123	3.14
3.15	10.00	DIETARY	RELATED PARTY SVCS	238	238	3.15
3.16	13.00	NURSING ADMINISTRATION	RELATED PARTY SVCS	13,595	13,595	3.16
3.17	15.00	PHARMACY	RELATED PARTY SVCS	32,648	32,648	3.17
3.18	16.00	MEDICAL RECORDS & LIBRARY	RELATED PARTY SVCS	2,227	2,227	3.18
3.19	30.00	ADULTS & PEDIATRICS	RELATED PARTY SVCS	66,874	66,874	3.19
3.20	50.00	OPERATING ROOM	RELATED PARTY SVCS	1,143	1,143	3.20
3.21	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SVCS	22,043	22,043	3.21
3.22	60.00	LABORATORY	RELATED PARTY SVCS	191,434	191,434	3.22
3.23	65.00	RESPIRATORY THERAPY	RELATED PARTY SVCS	93,786	93,786	3.23
3.24	66.00	PHYSICAL THERAPY	RELATED PARTY SVCS	334	334	3.24
3.25	71.00	MEDICAL SUPPLIES CHARGED TO	RELATED PARTY SVCS	35	35	3.25
3.26	90.00	CLINIC	RELATED PARTY SVCS	156,836	156,836	3.26
3.27	91.00	EMERGENCY	RELATED PARTY SVCS	39,060	39,060	3.27
3.28	190.00	GIFT, FLOWER, COFFEE SHOP &	RELATED PARTY SVCS	8,000	8,000	3.28
3.29	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY SVCS	5,309	5,309	3.29
4.00	194.00	OTHER NONALLOWABLE	RELATED PARTY SVCS	123,288	123,288	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,223,330	11,384,156	5.00

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

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

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

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

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

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

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

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 3:01 pm

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

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

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

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

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 3:01 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-894	0		1.00
2.00	1,088,556	0		2.00
3.00	328,969	0		3.00
3.01	761,096	0		3.01
3.02	-2,600,750	0		3.02
3.03	695,038	0		3.03
3.04	-409,326	0		3.04
3.05	-61,675	0		3.05
3.06	-5,130	0		3.06
3.07	-2,904	0		3.07
3.08	46,194	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
3.21	0	0		3.21
3.22	0	0		3.22
3.23	0	0		3.23
3.24	0	0		3.24
3.25	0	0		3.25
3.26	0	0		3.26
3.27	0	0		3.27
3.28	0	0		3.28
3.29	0	0		3.29
4.00	0	0		4.00
5.00	-160,826			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/28/2020 3:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	3,456	0	3,456	0	0	1.00
2.00	5.03	ADMINISTRATIVE & GENERAL	23,120	21,545	1,575	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	34,430	34,430	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	962,143	962,143	0	0	0	4.00
5.00	60.00	LABORATORY	40,000	40,000	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	116,820	116,370	450	0	0	6.00
7.00	90.00	CLINIC	1,057,615	1,057,615	0	0	0	7.00
8.00	91.00	EMERGENCY	1,693,034	828,407	864,627	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,930,618	3,060,510	870,108		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0		1.00
2.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	21,545		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	34,430		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	962,143		4.00
5.00	60.00	LABORATORY	0	0	0	40,000		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	116,370		6.00
7.00	90.00	CLINIC	0	0	0	1,057,615		7.00
8.00	91.00	EMERGENCY	0	0	0	828,407		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,060,510		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2020 3:01 pm	
				Physical Therapy		Cost	
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	3,405.25	3,227.50	4,333.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	97.40	84.70	63.52	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)	42.35	42.35	31.76			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)					331,671	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					273,369	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					275,248	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					880,288	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)					880,288	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)					880,288	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2020 3:01 pm		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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)	84.70	63.52	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)						880,288	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						880,288	63.00
64.00	Total cost of outside supplier services (from your records)						759,617	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

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				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	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	1,869.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.29	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)	40.15	40.15	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)					150,102	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)					150,102	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)					150,102	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)					150,102	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

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				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)	80.29	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)						150,102	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						150,102	63.00
64.00	Total cost of outside supplier services (from your records)						124,765	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2020 3:01 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						111	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						5.40	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	187.11	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	77.15	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.58	38.58	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)						14,436	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)						14,436	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)						14,436	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)						77.15	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						60,177	22.00
23.00	Total salary equivalency (see instructions)						60,177	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						4,282	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						4,282	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)						599	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						4,881	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						4,881	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2020 3:01 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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)	77.15	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)						60,177	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						4,881	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)						65,058	63.00
64.00	Total cost of outside supplier services (from your records)						13,004	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						4,282	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						599	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						4,881	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						599	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						599	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1350

Period:
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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	1,682,709	1,682,709			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	939,296		939,296		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,480,919	1,506	1,425	4,483,850	4.00
5.01	00570	ADMITTING	329,062	34,987	2,125	32	5.01
5.02	00540	PATIENT ACCOUNTING	761,096	2,274	0	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	7,015,224	185,191	272,698	721,691	5.03
6.00	00600	MAINTENANCE & REPAIRS	313,036	0	0	96,908	6.00
7.00	00700	OPERATION OF PLANT	1,242,656	369,331	31,686	30,469	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	181,613	0	0	0	8.00
9.00	00900	HOUSEKEEPING	556,130	32,476	273	103,091	9.00
10.00	01000	DIETARY	164,750	88,875	8,845	33,842	10.00
11.00	01100	CAFETERIA	375,759	29,060	0	76,850	11.00
13.00	01300	NURSING ADMINISTRATION	593,447	6,930	1,845	180,534	13.00
15.00	01500	PHARMACY	806,714	18,527	4,260	196,146	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	697,024	0	509	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,140,726	187,052	79,628	715,621	30.00
43.00	04300	NURSERY	131,372	8,663	0	40,386	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,357,513	143,294	146,452	433,787	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	793,500	41,573	0	243,936	52.00
53.00	05300	ANESTHESIOLOGY	27,030	3,052	31,252	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,116,074	97,114	183,646	286,439	54.00
57.00	05700	CT SCAN	321,195	5,247	7,913	33,731	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,095	16,765	63,399	33,758	58.00
60.00	06000	LABORATORY	1,681,046	46,918	21,326	289,722	60.00
65.00	06500	RESPIRATORY THERAPY	628,499	31,984	18,708	178,242	65.00
66.00	06600	PHYSICAL THERAPY	1,062,107	2,687	3,815	83,872	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,145	24,886	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	604,476	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,816,367	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	157,112	13,821	0	50,544	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	463,646	0	5,340	103,042	90.00
91.00	09100	EMERGENCY	2,214,592	139,563	45,907	444,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,171,930	1,531,776	931,052	4,377,132	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,056	9,244	107	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	202,475	141,689	8,137	51,171	192.00
194.00	07950	OTHER NONALLOWABLE	264,692	0	0	55,547	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,676,153	1,682,709	939,296	4,483,850	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1350

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Cost Center Description			PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5A.02	5.03	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING	763,370					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	8,194,804	8,194,804			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	409,944	110,212	520,156		6.00
7.00	00700	OPERATION OF PLANT	0	1,674,142	450,088	131,695	2,255,925	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	181,613	48,826	0	0	8.00
9.00	00900	HOUSEKEEPING	0	691,970	186,034	11,580	67,251	9.00
10.00	01000	DIETARY	0	296,312	79,663	31,691	184,037	10.00
11.00	01100	CAFETERIA	0	481,669	129,495	10,362	60,177	11.00
13.00	01300	NURSING ADMINISTRATION	0	782,756	210,442	2,471	14,351	13.00
15.00	01500	PHARMACY	0	1,025,647	275,742	6,606	38,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	697,533	187,530	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,280	3,176,713	854,050	66,698	387,337	30.00
43.00	04300	NURSERY	1,577	182,755	49,133	3,089	17,939	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,909	3,154,900	848,185	51,095	296,727	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,564	1,093,162	293,893	14,824	86,087	52.00
53.00	05300	ANESTHESIOLOGY	41,010	122,019	32,804	1,088	6,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,380	1,800,738	484,123	34,629	201,100	54.00
57.00	05700	CT SCAN	106,422	525,567	141,297	1,871	10,865	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,752	399,881	107,507	5,978	34,716	58.00
60.00	06000	LABORATORY	97,634	2,183,488	587,024	16,730	97,156	60.00
65.00	06500	RESPIRATORY THERAPY	12,822	876,407	235,619	11,405	66,231	65.00
66.00	06600	PHYSICAL THERAPY	37,537	1,208,027	324,774	958	5,565	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,851	332,527	89,399	8,874	51,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,256	631,491	169,774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,867	3,983,346	1,070,899	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,587	243,062	65,346	4,928	28,621	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	25,437	609,669	163,908	0	0	90.00
91.00	09100	EMERGENCY	68,485	2,945,893	791,994	49,765	289,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	763,370	37,906,035	7,987,761	466,337	1,943,379	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,407	12,476	3,296	19,142	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	403,472	108,472	50,523	293,404	192.00
194.00	07950	OTHER NONALLOWABLE	0	320,239	86,095	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	763,370	38,676,153	8,194,804	520,156	2,255,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	230,439					8.00
9.00	00900	HOUSEKEEPING	0	956,835				9.00
10.00	01000	DIETARY	0	0	591,703			10.00
11.00	01100	CAFETERIA	0	0	0	681,703		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,864	0	23,172	1,038,056	13.00
15.00	01500	PHARMACY	0	8,997	0	28,652	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	103,178	201,457	591,703	172,888	464,841	30.00
43.00	04300	NURSERY	2,811	9,083	0	6,687	17,979	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,249	138,997	0	83,170	223,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,047	55,142	0	40,679	109,374	52.00
53.00	05300	ANESTHESIOLOGY	0	8,093	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,774	73,782	0	60,415	0	54.00
57.00	05700	CT SCAN	5,973	6,887	0	7,291	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,716	0	0	5,433	0	58.00
60.00	06000	LABORATORY	3,492	49,934	0	56,143	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,318	22,772	0	37,196	0	65.00
66.00	06600	PHYSICAL THERAPY	299	10,460	0	26,423	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,222	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	19,586	0	7,987	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	264	29,745	0	24,008	0	90.00
91.00	09100	EMERGENCY	37,397	134,735	0	82,659	222,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	225,518	782,756	591,703	662,803	1,038,056	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,003	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,921	170,076	0	14,256	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	4,644	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	230,439	956,835	591,703	681,703	1,038,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,384,009					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	885,063				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	42,063	0	6,060,928	0	30.00
43.00	04300	NURSERY	0	1,828	0	291,304	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	57,865	0	4,881,806	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,089	0	1,721,297	0	52.00
53.00	05300	ANESTHESIOLOGY	0	47,547	0	217,870	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	92,035	0	2,765,596	0	54.00
57.00	05700	CT SCAN	0	123,387	0	823,138	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	43,770	0	601,001	0	58.00
60.00	06000	LABORATORY	0	113,198	0	3,107,165	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,866	0	1,269,814	0	65.00
66.00	06600	PHYSICAL THERAPY	0	43,521	0	1,620,027	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,058	0	506,614	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,167	0	822,432	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,384,009	130,863	0	6,569,117	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,912	0	386,442	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	29,492	0	857,086	0	90.00
91.00	09100	EMERGENCY	0	79,402	0	4,633,090	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,384,009	885,063	0	37,134,727	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	85,324	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,045,124	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	410,978	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,384,009	885,063	0	38,676,153	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1350

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

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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	828	1,506	1,425	3,759	4.00
5.01	00570	ADMITTING	3,687	34,987	2,125	40,799	5.01
5.02	00540	PATIENT ACCOUNTING	8,529	2,274	0	10,803	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	755,055	185,191	272,698	1,212,944	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,864	369,331	31,686	405,881	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,500	0	0	5,500	8.00
9.00	00900	HOUSEKEEPING	560	32,476	273	33,309	9.00
10.00	01000	DIETARY	560	88,875	8,845	98,280	10.00
11.00	01100	CAFETERIA	0	29,060	0	29,060	11.00
13.00	01300	NURSING ADMINISTRATION	300	6,930	1,845	9,075	13.00
15.00	01500	PHARMACY	97,603	18,527	4,260	120,390	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,789	0	509	8,298	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,295	187,052	79,628	277,975	30.00
43.00	04300	NURSERY	0	8,663	0	8,663	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,606	143,294	146,452	324,352	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,573	0	41,573	52.00
53.00	05300	ANESTHESIOLOGY	1,128	3,052	31,252	35,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,030	97,114	183,646	282,790	54.00
57.00	05700	CT SCAN	0	5,247	7,913	13,160	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,765	63,399	80,164	58.00
60.00	06000	LABORATORY	30,205	46,918	21,326	98,449	60.00
65.00	06500	RESPIRATORY THERAPY	17,154	31,984	18,708	67,846	65.00
66.00	06600	PHYSICAL THERAPY	1,108	2,687	3,815	7,610	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,467	24,886	0	34,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,388	13,821	0	15,209	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	5,340	5,340	90.00
91.00	09100	EMERGENCY	4,356	139,563	45,907	189,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	998,012	1,531,776	931,052	3,460,840	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35	9,244	107	9,386	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,854	141,689	8,137	164,680	192.00
194.00	07950	OTHER NONALLOWABLE	7,800	0	0	7,800	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,020,701	1,682,709	939,296	3,642,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMITTING	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5.02	5.03	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	40,799					5.01
5.02	00540	PATIENT ACCOUNTING	0	10,803				5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	0	1,213,551			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	16,321	16,402		6.00
7.00	00700	OPERATION OF PLANT	0	0	66,653	4,154	476,714	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	7,231	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	27,549	365	14,211	9.00
10.00	01000	DIETARY	0	0	11,797	999	38,890	10.00
11.00	01100	CAFETERIA	0	0	19,177	327	12,716	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	31,164	78	3,033	13.00
15.00	01500	PHARMACY	0	0	40,834	208	8,107	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	27,771	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,940	516	126,474	2,103	81,850	30.00
43.00	04300	NURSERY	84	22	7,276	97	3,791	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,669	710	125,606	1,611	62,703	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	511	136	43,522	467	18,192	52.00
53.00	05300	ANESTHESIOLOGY	2,193	583	4,858	34	1,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,245	1,129	71,693	1,092	42,496	54.00
57.00	05700	CT SCAN	5,691	1,514	20,924	59	2,296	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,019	537	15,920	189	7,336	58.00
60.00	06000	LABORATORY	5,221	1,389	86,931	528	20,531	60.00
65.00	06500	RESPIRATORY THERAPY	686	182	34,892	360	13,996	65.00
66.00	06600	PHYSICAL THERAPY	2,007	534	48,095	30	1,176	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	741	197	13,239	280	10,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	976	260	25,142	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,013	1,550	158,586	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	780	208	9,677	155	6,048	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,360	362	24,273	0	0	90.00
91.00	09100	EMERGENCY	3,663	974	117,285	1,569	61,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,799	10,803	1,182,890	14,705	410,668	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,848	104	4,045	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	16,063	1,593	62,001	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	12,750	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,799	10,803	1,213,551	16,402	476,714	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00540	PATIENT ACCOUNTING					5.02
5.03	00550	ADMINISTRATIVE & GENERAL					5.03
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,731				8.00
9.00	00900	HOUSEKEEPING	0	75,520			9.00
10.00	01000	DIETARY	0	0	149,994		10.00
11.00	01100	CAFETERIA	0	0	0	61,344	11.00
13.00	01300	NURSING ADMINISTRATION	0	384	0	2,085	45,970
15.00	01500	PHARMACY	0	710	0	2,578	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,700	15,899	149,994	15,557	20,585
43.00	04300	NURSERY	155	717	0	602	796
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,505	10,971	0	7,484	9,903
52.00	05200	DELIVERY ROOM & LABOR ROOM	942	4,352	0	3,661	4,844
53.00	05300	ANESTHESIOLOGY	0	639	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,037	5,823	0	5,437	0
57.00	05700	CT SCAN	330	544	0	656	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	205	0	0	489	0
60.00	06000	LABORATORY	193	3,941	0	5,052	0
65.00	06500	RESPIRATORY THERAPY	294	1,797	0	3,347	0
66.00	06600	PHYSICAL THERAPY	17	826	0	2,378	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	649	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	OTHER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	1,546	0	719	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15	2,348	0	2,160	0
91.00	09100	EMERGENCY	2,066	10,634	0	7,438	9,842
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,459	61,780	149,994	59,643	45,970
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	316	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	272	13,424	0	1,283	0
194.00	07950	OTHER NONALLOWABLE	0	0	0	418	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	12,731	75,520	149,994	61,344	45,970

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	172,991					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,069				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,716	0	700,909	0	30.00
43.00	04300	NURSERY	0	75	0	22,312	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,361	0	550,239	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	452	0	118,857	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,940	0	47,014	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,755	0	419,737	0	54.00
57.00	05700	CT SCAN	0	5,035	0	50,237	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,786	0	108,673	0	58.00
60.00	06000	LABORATORY	0	4,619	0	227,097	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	607	0	124,156	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,776	0	64,519	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	655	0	61,004	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	864	0	27,242	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,991	5,295	0	344,435	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	690	0	35,074	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,203	0	37,147	0	90.00
91.00	09100	EMERGENCY	0	3,240	0	407,981	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	172,991	36,069	0	3,346,633	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,699	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	259,359	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	21,015	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	172,991	36,069	0	3,642,706	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1350

Period:
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To 06/30/2020Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00570	ADMITTING	5.01
5.02	00540	PATIENT ACCOUNTING	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	5.03
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	OTHER	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONALLOWABLE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE 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	170,932					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,035,770				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	153	1,571	12,963,578			4.00
5.01	00570	ADMITTING	3,554	2,343	93	130,841,230		5.01
5.02	00540	PATIENT ACCOUNTING	231	0	0	0	130,841,230	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	18,812	300,705	2,086,538	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	280,178	0	0	6.00
7.00	00700	OPERATION OF PLANT	37,517	34,940	88,091	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,299	301	298,054	0	0	9.00
10.00	01000	DIETARY	9,028	9,754	97,844	0	0	10.00
11.00	01100	CAFETERIA	2,952	0	222,187	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	704	2,034	521,953	0	0	13.00
15.00	01500	PHARMACY	1,882	4,698	567,090	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	561	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,001	87,807	2,068,981	6,218,651	6,218,651	30.00
43.00	04300	NURSERY	880	0	116,763	270,309	270,309	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,556	161,494	1,254,151	8,554,862	8,554,862	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,223	0	705,259	1,639,382	1,639,382	52.00
53.00	05300	ANESTHESIOLOGY	310	34,462	0	7,029,431	7,029,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,865	202,508	828,144	13,606,520	13,606,520	54.00
57.00	05700	CT SCAN	533	8,726	97,522	18,241,713	18,241,713	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,703	69,911	97,601	6,470,960	6,470,960	58.00
60.00	06000	LABORATORY	4,766	23,516	837,636	16,735,421	16,735,421	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	20,630	515,328	2,197,816	2,197,816	65.00
66.00	06600	PHYSICAL THERAPY	273	4,207	242,488	6,434,159	6,434,159	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,528	0	0	2,374,107	2,374,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,129,317	3,129,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,339,316	19,339,316	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,404	0	146,132	2,500,278	2,500,278	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,889	297,912	4,360,125	4,360,125	90.00
91.00	09100	EMERGENCY	14,177	50,622	1,285,091	11,738,863	11,738,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,600	1,026,679	12,655,036	130,841,230	130,841,230	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	939	118	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,393	8,973	147,945	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	160,597	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,682,709	939,296	4,483,850	366,206	763,370	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.844318	0.906858	0.345881	0.002799	0.005834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,759	40,799	10,803	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000290	0.000312	0.000083	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A.03	5.03	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00540	PATIENT ACCOUNTING					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-8,194,804	30,481,349			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	409,944	148,182		6.00
7.00	00700	OPERATION OF PLANT	0	1,674,142	37,517	110,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	181,613	0	0	8.00
9.00	00900	HOUSEKEEPING	0	691,970	3,299	3,299	9.00
10.00	01000	DIETARY	0	296,312	9,028	9,028	10.00
11.00	01100	CAFETERIA	0	481,669	2,952	2,952	11.00
13.00	01300	NURSING ADMINISTRATION	0	782,756	704	704	13.00
15.00	01500	PHARMACY	0	1,025,647	1,882	1,882	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	697,533	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,176,713	19,001	19,001	30.00
43.00	04300	NURSERY	0	182,755	880	880	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,154,900	14,556	14,556	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,093,162	4,223	4,223	52.00
53.00	05300	ANESTHESIOLOGY	0	122,019	310	310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,800,738	9,865	9,865	54.00
57.00	05700	CT SCAN	0	525,567	533	533	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	399,881	1,703	1,703	58.00
60.00	06000	LABORATORY	0	2,183,488	4,766	4,766	60.00
65.00	06500	RESPIRATORY THERAPY	0	876,407	3,249	3,249	65.00
66.00	06600	PHYSICAL THERAPY	0	1,208,027	273	273	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	332,527	2,528	2,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	631,491	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,983,346	0	0	73.00
76.00	03020	OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	243,062	1,404	1,404	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	609,669	0	0	90.00
91.00	09100	EMERGENCY	0	2,945,893	14,177	14,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,194,804	29,711,231	132,850	95,333	180,808
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,407	939	939	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	403,472	14,393	14,393	192.00
194.00	07950	OTHER NONALLOWABLE	0	320,239	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		8,194,804	520,156	2,255,925	230,439
203.00		Unit cost multiplier (Wkst. B, Part I)		0.268847	3.510251	20.385171	1.247282
204.00		Cost to be allocated (per Wkst. B, Part II)		1,213,551	16,402	476,714	12,731
205.00		Unit cost multiplier (Wkst. B, Part II)		0.039813	0.110688	4.307722	0.068908
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description			HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	22,228					9.00
10.00	01000	DIETARY	0	28,932				10.00
11.00	01100	CAFETERIA	0	0	14,680			11.00
13.00	01300	NURSING ADMINISTRATION	113	0	499	8,314		13.00
15.00	01500	PHARMACY	209	0	617	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,680	28,932	3,723	3,723	0	30.00
43.00	04300	NURSERY	211	0	144	144	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,229	0	1,791	1,791	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,281	0	876	876	0	52.00
53.00	05300	ANESTHESIOLOGY	188	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,714	0	1,301	0	0	54.00
57.00	05700	CT SCAN	160	0	157	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	117	0	0	58.00
60.00	06000	LABORATORY	1,160	0	1,209	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	529	0	801	0	0	65.00
66.00	06600	PHYSICAL THERAPY	243	0	569	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	191	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	455	0	172	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	691	0	517	0	0	90.00
91.00	09100	EMERGENCY	3,130	0	1,780	1,780	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,184	28,932	14,273	8,314	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,951	0	307	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	100	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	956,835	591,703	681,703	1,038,056	1,384,009	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.046383	20.451507	46.437534	124.856387	13,840.090000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,520	149,994	61,344	45,970	172,991	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.397517	5.184363	4.178747	5.529228	1,729.910000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00540	PATIENT ACCOUNTING		5.02
5.03	00550	ADMINISTRATIVE & GENERAL		5.03
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,841,230	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	6,218,651	30.00
43.00	04300	NURSERY	270,309	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,554,862	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,639,382	52.00
53.00	05300	ANESTHESIOLOGY	7,029,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,606,520	54.00
57.00	05700	CT SCAN	18,241,713	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,470,960	58.00
60.00	06000	LABORATORY	16,735,421	60.00
65.00	06500	RESPIRATORY THERAPY	2,197,816	65.00
66.00	06600	PHYSICAL THERAPY	6,434,159	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,374,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,129,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,339,316	73.00
76.00	03020	OTHER	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,500,278	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4,360,125	90.00
91.00	09100	EMERGENCY	11,738,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,841,230	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	885,063	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006764	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,069	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000276	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,060,928		6,060,928	0
43.00	04300	NURSERY	291,304		291,304	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,881,806		4,881,806	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,721,297		1,721,297	0
53.00	05300	ANESTHESIOLOGY	217,870		217,870	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,765,596		2,765,596	0
57.00	05700	CT SCAN	823,138		823,138	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	601,001		601,001	0
60.00	06000	LABORATORY	3,107,165		3,107,165	0
65.00	06500	RESPIRATORY THERAPY	1,269,814	0	1,269,814	0
66.00	06600	PHYSICAL THERAPY	1,620,027	0	1,620,027	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	506,614		506,614	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	822,432		822,432	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,569,117		6,569,117	0
76.00	03020	OTHER	0		0	0
76.97	07697	CARDIAC REHABILITATION	386,442		386,442	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	857,086		857,086	0
91.00	09100	EMERGENCY	4,633,090		4,633,090	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	906,596		906,596	0
200.00		Subtotal (see instructions)	38,041,323	0	38,041,323	0
201.00		Less Observation Beds	906,596		906,596	0
202.00		Total (see instructions)	37,134,727	0	37,134,727	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,087,568		5,087,568		30.00
43.00	04300	NURSERY	270,309		270,309		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,801,901	6,752,961	8,554,862	0.570647	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	953,745	685,637	1,639,382	1.049967	0.000000
53.00	05300	ANESTHESIOLOGY	1,441,150	5,588,281	7,029,431	0.030994	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	843,028	12,763,492	13,606,520	0.203255	0.000000
57.00	05700	CT SCAN	1,038,161	17,203,552	18,241,713	0.045124	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	298,770	6,172,190	6,470,960	0.092877	0.000000
60.00	06000	LABORATORY	3,027,852	13,707,569	16,735,421	0.185664	0.000000
65.00	06500	RESPIRATORY THERAPY	745,937	1,451,879	2,197,816	0.577762	0.000000
66.00	06600	PHYSICAL THERAPY	1,105,058	5,329,101	6,434,159	0.251785	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	751,653	1,622,454	2,374,107	0.213391	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,106	876,211	3,129,317	0.262815	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,058,171	17,281,145	19,339,316	0.339677	0.000000
76.00	03020	OTHER	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	76,969	2,423,309	2,500,278	0.154560	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,244	4,357,881	4,360,125	0.196574	0.000000
91.00	09100	EMERGENCY	257,375	11,481,488	11,738,863	0.394680	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,169	1,073,914	1,131,083	0.801529	0.000000
200.00		Subtotal (see instructions)	22,070,166	108,771,064	130,841,230		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	22,070,166	108,771,064	130,841,230		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2019
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Part I
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	OTHER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,060,928		6,060,928	0	6,060,928	30.00	
43.00	04300	NURSERY	291,304		291,304	0	291,304	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,881,806		4,881,806	0	4,881,806	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,721,297		1,721,297	0	1,721,297	52.00	
53.00	05300	ANESTHESIOLOGY	217,870		217,870	0	217,870	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,765,596		2,765,596	0	2,765,596	54.00	
57.00	05700	CT SCAN	823,138		823,138	0	823,138	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	601,001		601,001	0	601,001	58.00	
60.00	06000	LABORATORY	3,107,165		3,107,165	0	3,107,165	60.00	
65.00	06500	RESPIRATORY THERAPY	1,269,814	0	1,269,814	0	1,269,814	65.00	
66.00	06600	PHYSICAL THERAPY	1,620,027	0	1,620,027	0	1,620,027	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	506,614		506,614	0	506,614	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	822,432		822,432	0	822,432	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,569,117		6,569,117	0	6,569,117	73.00	
76.00	03020	OTHER	0		0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	386,442		386,442	0	386,442	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	857,086		857,086	0	857,086	90.00	
91.00	09100	EMERGENCY	4,633,090		4,633,090	0	4,633,090	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	906,596		906,596	0	906,596	92.00	
200.00		Subtotal (see instructions)	38,041,323	0	38,041,323	0	38,041,323	200.00	
201.00		Less Observation Beds	906,596		906,596	0	906,596	201.00	
202.00		Total (see instructions)	37,134,727	0	37,134,727	0	37,134,727	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,087,568		5,087,568			30.00
43.00	04300	NURSERY	270,309		270,309			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,801,901	6,752,961	8,554,862	0.570647	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	953,745	685,637	1,639,382	1.049967	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,441,150	5,588,281	7,029,431	0.030994	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	843,028	12,763,492	13,606,520	0.203255	0.000000	54.00
57.00	05700	CT SCAN	1,038,161	17,203,552	18,241,713	0.045124	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	298,770	6,172,190	6,470,960	0.092877	0.000000	58.00
60.00	06000	LABORATORY	3,027,852	13,707,569	16,735,421	0.185664	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	745,937	1,451,879	2,197,816	0.577762	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,105,058	5,329,101	6,434,159	0.251785	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	751,653	1,622,454	2,374,107	0.213391	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,106	876,211	3,129,317	0.262815	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,058,171	17,281,145	19,339,316	0.339677	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	76,969	2,423,309	2,500,278	0.154560	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,244	4,357,881	4,360,125	0.196574	0.000000	90.00
91.00	09100	EMERGENCY	257,375	11,481,488	11,738,863	0.394680	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,169	1,073,914	1,131,083	0.801529	0.000000	92.00
200.00		Subtotal (see instructions)	22,070,166	108,771,064	130,841,230			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,070,166	108,771,064	130,841,230			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	OTHER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 11/28/2020 3:01 pm	
					Title XVIII		Hospital	Cost
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	550,239	8,554,862	0.064319	776,883	49,968	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	118,857	1,639,382	0.072501	467	34	52.00
53.00	05300	ANESTHESIOLOGY	47,014	7,029,431	0.006688	560,703	3,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,737	13,606,520	0.030848	539,377	16,639	54.00
57.00	05700	CT SCAN	50,237	18,241,713	0.002754	535,796	1,476	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,673	6,470,960	0.016794	152,625	2,563	58.00
60.00	06000	LABORATORY	227,097	16,735,421	0.013570	1,517,550	20,593	60.00
65.00	06500	RESPIRATORY THERAPY	124,156	2,197,816	0.056491	521,403	29,455	65.00
66.00	06600	PHYSICAL THERAPY	64,519	6,434,159	0.010028	582,435	5,841	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,004	2,374,107	0.025696	370,255	9,514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,242	3,129,317	0.008705	1,003,865	8,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	344,435	19,339,316	0.017810	1,016,663	18,107	73.00
76.00	03020	OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,074	2,500,278	0.014028	44,325	622	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	37,147	4,360,125	0.008520	375	3	90.00
91.00	09100	EMERGENCY	407,981	11,738,863	0.034755	11,726	408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	104,842	1,131,083	0.092692	4,486	416	92.00
200.00		Total (lines 50 through 199)	2,728,254	125,483,353		7,638,934	168,128	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 3:01 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
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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	8,554,862	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,639,382	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,029,431	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,606,520	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	18,241,713	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,470,960	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	16,735,421	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,197,816	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,434,159	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,374,107	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,129,317	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,339,316	0.000000	73.00
76.00	03020	OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,500,278	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,360,125	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,738,863	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,131,083	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	125,483,353		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	776,883	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	467	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	560,703	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	539,377	0	0	0 54.00
57.00	05700	CT SCAN	0.000000	535,796	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	152,625	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	1,517,550	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	521,403	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	582,435	0	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	370,255	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,003,865	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,016,663	0	0	0 73.00
76.00	03020	OTHER	0.000000	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	44,325	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	375	0	0	0 90.00
91.00	09100	EMERGENCY	0.000000	11,726	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,486	0	0	0 92.00
200.00		Total (lines 50 through 199)		7,638,934	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/28/2020 3:01 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.570647	0	2,246,903	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049967	0	146,541	0	0
53.00	05300	ANESTHESIOLOGY	0.030994	0	1,630,641	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203255	0	5,069,547	0	0
57.00	05700	CT SCAN	0.045124	0	7,269,614	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.092877	0	2,234,199	0	0
60.00	06000	LABORATORY	0.185664	0	5,497,465	0	0
65.00	06500	RESPIRATORY THERAPY	0.577762	0	548,669	0	0
66.00	06600	PHYSICAL THERAPY	0.251785	0	1,905,848	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213391	0	466,595	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262815	0	205,016	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.339677	0	10,226,955	2,297	0
76.00	03020	OTHER	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.154560	0	1,113,191	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.196574	0	1,997,001	2,278	0
91.00	09100	EMERGENCY	0.394680	0	3,980,773	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.801529	0	669,097	0	0
200.00		Subtotal (see instructions)		0	45,208,055	4,575	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00		Net Charges (line 200 - line 201)		0	45,208,055	4,575	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/28/2020 3:01 pm

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,282,188	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	153,863	0		52.00
53.00	05300	ANESTHESIOLOGY	50,540	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,030,411	0		54.00
57.00	05700	CT SCAN	328,034	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,506	0		58.00
60.00	06000	LABORATORY	1,020,681	0		60.00
65.00	06500	RESPIRATORY THERAPY	317,000	0		65.00
66.00	06600	PHYSICAL THERAPY	479,864	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,567	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,881	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,473,861	780		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	172,055	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	392,558	448		90.00
91.00	09100	EMERGENCY	1,571,131	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	536,301	0		92.00
200.00		Subtotal (see instructions)	11,169,441	1,228		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	11,169,441	1,228		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 3:01 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,348	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,826	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,180	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		200	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)		289	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		17	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)		16	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,941	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)		161	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)		253	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		159.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,060,928	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)		2,705	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)		2,546	25.00
26.00	Total swing-bed cost (see instructions)		691,514	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,369,414	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,369,414	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,403.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,723,999	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,723,999	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,042,152	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,766,151	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)					225,947	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					355,060	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					581,007	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)					646	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,403.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					906,596	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1350		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/28/2020 3:01 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	700,909	6,060,928	0.115644	906,596	104,842	90.00
91.00	Nursing School cost	0	6,060,928	0.000000	906,596	0	91.00
92.00	Allied health cost	0	6,060,928	0.000000	906,596	0	92.00
93.00	All other Medical Education	0	6,060,928	0.000000	906,596	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 3:01 pm	
Cost Center Description			Title XVIII	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		2,079,186		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.570647	776,883	443,326	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049967	467	490	52.00
53.00	05300	ANESTHESIOLOGY	0.030994	560,703	17,378	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203255	539,377	109,631	54.00
57.00	05700	CT SCAN	0.045124	535,796	24,177	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.092877	152,625	14,175	58.00
60.00	06000	LABORATORY	0.185664	1,517,550	281,754	60.00
65.00	06500	RESPIRATORY THERAPY	0.577762	521,403	301,247	65.00
66.00	06600	PHYSICAL THERAPY	0.251785	582,435	146,648	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213391	370,255	79,009	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262815	1,003,865	263,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.339677	1,016,663	345,337	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.154560	44,325	6,851	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.196574	375	74	90.00
91.00	09100	EMERGENCY	0.394680	11,726	4,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.801529	4,486	3,596	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,638,934	2,042,152	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,638,934		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1350 Component CCN: 14-Z350	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 3:01 pm	
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.570647	180	103	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049967	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030994	551	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203255	19,309	3,925	54.00
57.00	05700	CT SCAN	0.045124	20,556	928	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.092877	0	0	58.00
60.00	06000	LABORATORY	0.185664	145,519	27,018	60.00
65.00	06500	RESPIRATORY THERAPY	0.577762	35,418	20,463	65.00
66.00	06600	PHYSICAL THERAPY	0.251785	231,183	58,208	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213391	33,134	7,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262815	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.339677	107,391	36,478	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.154560	2,469	382	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.196574	0	0	90.00
91.00	09100	EMERGENCY	0.394680	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.801529	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		595,710	154,592	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)		595,710		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 3:01 pm
			Component CCN:14-Z350		
			Title XIX	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.570647	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049967	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030994	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203255	0	54.00
57.00	05700	CT SCAN	0.045124	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.092877	0	58.00
60.00	06000	LABORATORY	0.185664	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.577762	0	65.00
66.00	06600	PHYSICAL THERAPY	0.251785	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213391	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262815	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.339677	0	73.00
76.00	03020	OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.154560	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.196574	0	90.00
91.00	09100	EMERGENCY	0.394680	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.801529	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/28/2020 3:01 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,170,669	1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)		0	2.00
3.00	OPPIs 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)		11,170,669	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 charge basis 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)		11,282,376	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)		89,377	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		8,036,158	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)		3,156,841	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)		3,156,841	30.00
31.00	Primary payer payments		93	31.00
32.00	Subtotal (line 30 minus line 31)		3,156,748	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,680,624	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,092,406	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,062,597	36.00
37.00	Subtotal (see instructions)		4,249,154	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)		4,249,154	40.00
40.01	Sequestration adjustment (see instructions)		70,961	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		3,297,716	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)		880,477	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: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/28/2020 3:01 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,396,141		3,200,221	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/19/2020	40,098	05/19/2020	97,495	3.01
3.02		06/30/2020	232,561		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)		272,659		97,495	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,668,800		3,297,716	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		880,477	6.01
6.02	SETTLEMENT TO PROGRAM		349,927		0	6.02
7.00	Total Medicare program liability (see instructions)		4,318,873		4,178,193	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1350

Period:

Worksheet E-1

Component CCN: 14-Z350

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/28/2020 3:01 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		637,820		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/19/2020	22,264		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)		22,264		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)		660,084		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		62,157		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		722,241		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/28/2020 3:01 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1350

Period:

Worksheet E-2

Component CCN:14-Z350

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/28/2020 3:01 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		586,817	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)		156,138	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		414	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)		742,955	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		742,955	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)		742,955	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		8,448	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		734,507	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)		734,507	0	19.00
19.01	Sequestration adjustment (see instructions)		12,266	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		660,084	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)		62,157	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 - SWING BEDS

Provider CCN:14-1350

Period:

Worksheet E-2

Component CCN:14-Z350

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/28/2020 3:01 pm

		Title XIX	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		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		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration		0	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		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)		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	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: 14-1350	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/28/2020 3:01 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		4,766,151	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		4,766,151	4.00
5.00	Primary payer payments		1,000	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4,812,813	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		4,812,813	19.00
20.00	Deductibles (exclude professional component)		596,496	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		4,216,317	22.00
23.00	Coinsurance		682	23.00
24.00	Subtotal (line 22 minus line 23)		4,215,635	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		271,674	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		176,588	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		181,067	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		4,392,223	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		4,392,223	30.00
30.01	Sequestration adjustment (see instructions)		73,350	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		4,668,800	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)		-349,927	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: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/28/2020 3:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	11,096,666	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,935,478	0	0	0	4.00
5.00	Other receivable	38,558	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,957,841	0	0	0	6.00
7.00	Inventory	878,964	0	0	0	7.00
8.00	Prepaid expenses	397,650	0	0	0	8.00
9.00	Other current assets	445,586	0	0	0	9.00
10.00	Due from other funds	-1,804,635	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,030,426	0	0	0	11.00
FIXED ASSETS						
12.00	Land	462,220	0	0	0	12.00
13.00	Land improvements	1,911,747	0	0	0	13.00
14.00	Accumulated depreciation	-1,459,660	0	0	0	14.00
15.00	Buildings	45,409,838	0	0	0	15.00
16.00	Accumulated depreciation	-21,133,829	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	25,162,618	0	0	0	23.00
24.00	Accumulated depreciation	-20,812,106	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,540,828	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	63,095,071	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	4,358,439	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	67,453,510	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	115,024,764	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,629,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,467,604	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,152,019	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	20,281	0	0	0	43.00
44.00	Other current liabilities	1,534,310	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,803,902	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,581,030	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,301,025	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,882,055	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	33,685,957	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	81,338,807				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)	81,338,807	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	115,024,764	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/28/2020 3:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		77,830,277		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,748,407				2.00
3.00	Total (sum of line 1 and line 2)		82,578,684		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)		82,578,684		0		11.00
12.00	TRANSFER OF ASSETS	1,239,877		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)		1,239,877		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		81,338,807		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	TRANSFER OF ASSETS		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: 14-1350

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2020 3:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,253,210		5,253,210	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	167,131		167,131	5.00
6.00	Swing bed - NF	11,279		11,279	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,431,620		5,431,620	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,431,620		5,431,620	17.00
18.00	Ancillary services	16,507,017	94,534,859	111,041,876	18.00
19.00	Outpatient services	321,275	17,137,591	17,458,866	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 FEES	17,712	254,138	271,850	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,277,624	111,926,588	134,204,212	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,970,479		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)		47,970,479		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1350

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/28/2020 3:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	134,204,212	1.00
2.00	Less contractual allowances and discounts on patients' accounts	84,366,689	2.00
3.00	Net patient revenues (line 1 minus line 2)	49,837,523	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,970,479	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,867,044	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,637,884	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	3,497	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	27,662	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	167,697	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	321,362	24.00
24.01	GRANTS	395,155	24.01
24.02	AFFILIATE COSTS/INTERCOMPANY REVENUE	1,766,819	24.02
24.50	COVID-19 PHE Funding	3,648,776	24.50
25.00	Total other income (sum of lines 6-24)	7,968,852	25.00
26.00	Total (line 5 plus line 25)	9,835,896	26.00
27.00	LOSS ON DISPOSALS	2,855	27.00
27.01	PENSION	2,569,799	27.01
27.02	NON-OPERATING LOSS	2,514,835	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	5,087,489	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,748,407	29.00