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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1339	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/26/2020 1:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2020 Time: 1:37 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (14-1339) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) CHRISTINE GOLDESBERRY-CURRY
Officer or Administrator of Provider(s)

DIRECTOR OF FINANCE
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-343,323	-1,147,752	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	-70,002	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-413,325	-1,147,752	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 1:37 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	2.00

		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	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2018	09/30/2019	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 1:37 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.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2020 1:37 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 1:37 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	2.00	3.00	
	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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
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)	N	N	0	76.00

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	24,735	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 1:37 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2020 1:37 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)	Y			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	12/26/2019	Y	12/26/2019	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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 1:37 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.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1339	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 1:37 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2020 1:37 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	51,748.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	51,748.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	51,748.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2020 1:37 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)	1,653	36	2,155			1.00
2.00	HMO and other (see instructions)	178	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	2,020	0	2,659			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	165			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,673	36	4,979			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)	3,673	36	4,979	0.00	263.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	263.15	27.00
28.00	Observation Bed Days		5	253			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			12			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2020 1:37 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	425	13	610	1.00
2.00	HMO and other (see instructions)			35	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	425	13	610	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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-10 | Date/Time Prepared: 2/26/2020 1:37 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)	0.312433	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,466,816	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,259,722	5.00
6.00	Medicaid charges	23,309,168	6.00
7.00	Medicaid cost (line 1 times line 6)	7,282,553	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)	2,556,015	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	22,561	9.00
10.00	Stand-alone CHIP charges	233,651	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	73,000	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	50,439	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)	2,606,454	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)	424,850	69,054	493,904	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	132,737	69,054	201,791	21.00
22.00	Payments received from patients for amounts previously written off as charity care	8,124	0	8,124	22.00
23.00	Cost of charity care (line 21 minus line 22)	124,613	69,054	193,667	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)	2,584,844	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	796,073	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,224,728	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,360,116	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	853,600	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,047,267	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,653,721	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/26/2020 1:37 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		2,732,690	2,732,690	524,613	3,257,303	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,138,416	1,138,416	71,289	1,209,705	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	599,174	4,397,706	4,996,880	-73,280	4,923,600	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,374,922	4,564,960	6,939,882	-22,453	6,917,429	5.00
7.00	00700	OPERATION OF PLANT	771,892	1,001,773	1,773,665	0	1,773,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,672	133,621	152,293	0	152,293	8.00
9.00	00900	HOUSEKEEPING	375,331	78,899	454,230	0	454,230	9.00
10.00	01000	DIETARY	410,243	399,278	809,521	-595,401	214,120	10.00
11.00	01100	CAFETERIA	0	0	0	595,401	595,401	11.00
13.00	01300	NURSING ADMINISTRATION	745,606	76,393	821,999	0	821,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	159,004	103,165	262,169	-773	261,396	14.00
15.00	01500	PHARMACY	454,665	1,182,012	1,636,677	-1,112,268	524,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	475,318	45,290	520,608	0	520,608	16.00
17.00	01700	SOCIAL SERVICE	63,706	4,541	68,247	0	68,247	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	666,435	28,082	694,517	73,280	767,797	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,352,557	615,998	2,968,555	-82	2,968,473	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	572,123	925,828	1,497,951	-409,633	1,088,318	50.00
53.00	05300	ANESTHESIOLOGY	0	246,869	246,869	-9,272	237,597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,185,592	725,050	1,910,642	-299	1,910,343	54.00
60.00	06000	LABORATORY	839,582	1,155,107	1,994,689	-64	1,994,625	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	519,270	103,670	622,940	-47,708	575,232	65.00
66.00	06600	PHYSICAL THERAPY	1,113,193	122,711	1,235,904	0	1,235,904	66.00
67.00	06700	OCCUPATIONAL THERAPY	296,976	26,681	323,657	0	323,657	67.00
68.00	06800	SPEECH PATHOLOGY	124,647	12,051	136,698	0	136,698	68.00
69.00	06900	ELECTROCARDIOLOGY	178,651	26,760	205,411	0	205,411	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	123,844	123,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	358,750	358,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,112,128	1,112,128	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	185,719	164,205	349,924	0	349,924	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,694,414	2,964,209	4,658,623	-14,623	4,644,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		573,449	573,449	-573,449	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,177,692	23,549,414	39,727,106	0	39,727,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	252	252	0	252	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,177,692	23,549,666	39,727,358	0	39,727,358	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/26/2020 1:37 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	-1,827,510	1,429,793		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	30,207	1,239,912		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-270,883	4,652,717		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-857,583	6,059,846		5.00
7.00	00700	OPERATION OF PLANT	-10,401	1,763,264		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	152,293		8.00
9.00	00900	HOUSEKEEPING	0	454,230		9.00
10.00	01000	DIETARY	0	214,120		10.00
11.00	01100	CAFETERIA	-177,959	417,442		11.00
13.00	01300	NURSING ADMINISTRATION	0	821,999		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	261,396		14.00
15.00	01500	PHARMACY	0	524,409		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,835	512,773		16.00
17.00	01700	SOCIAL SERVICE	0	68,247		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-767,797	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-222,000	2,746,473		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-29,646	1,058,672		50.00
53.00	05300	ANESTHESIOLOGY	-55,832	181,765		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,910,343		54.00
60.00	06000	LABORATORY	0	1,994,625		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	575,232		65.00
66.00	06600	PHYSICAL THERAPY	0	1,235,904		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	323,657		67.00
68.00	06800	SPEECH PATHOLOGY	0	136,698		68.00
69.00	06900	ELECTROCARDIOLOGY	-528	204,883		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	123,844		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	358,750		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,112,128		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	349,924		76.00
76.01	03950	DIABETIC EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,348,859	2,295,141		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,546,626	33,180,480		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	252		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,546,626	33,180,732		200.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/26/2020 1:37 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	301,733	293,668	1.00
	0		301,733	293,668	
	B - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,112,128	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
	0		0	1,112,128	
	C - IMPLANTS & MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	123,844	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	358,750	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
	0		0	482,594	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	22,453	1.00
	0		0	22,453	
	E - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	610,158	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	61,393	2.00
	0		0	671,551	
	F - BOND AMORTIZATION EXPENSE				
1.00	INTEREST EXPENSE	113.00	0	98,102	1.00
	0		0	98,102	
	G - CRNA BENEFITS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	73,280	1.00
	0		0	73,280	
500.00	Grand Total: Increases		301,733	2,753,776	500.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/26/2020 1:37 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	301,733	293,668	0		1.00
	0		301,733	293,668			
	B - DRUG EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	18	0		1.00
2.00	PHARMACY	15.00	0	1,111,394	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	82	0		3.00
4.00	OPERATING ROOM	50.00	0	203	0		4.00
5.00	LABORATORY	60.00	0	64	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	32	0		6.00
7.00	EMERGENCY	91.00	0	335	0		7.00
	0		0	1,112,128			
	C - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	755	0		1.00
2.00	PHARMACY	15.00	0	874	0		2.00
3.00	OPERATING ROOM	50.00	0	409,430	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	9,272	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	299	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	47,676	0		6.00
7.00	EMERGENCY	91.00	0	14,288	0		7.00
	0		0	482,594			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,453	0		1.00
	0		0	22,453			
	E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	671,551	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	671,551			
	F - BOND AMORTIZATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,102	14		1.00
	0		0	98,102			
	G - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	73,280	0		1.00
	0		0	73,280			
500.00	Grand Total: Decreases		301,733	2,753,776			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2020 1:37 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	948,070	0	0	0	0	1.00
2.00	Land Improvements	3,045,962	1,102,068	0	1,102,068	0	2.00
3.00	Buildings and Fixtures	25,561,465	343,426	0	343,426	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	22,877,705	1,603,842	0	1,603,842	51,625	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,433,202	3,049,336	0	3,049,336	51,625	8.00
9.00	Reconciling Items	-5,839,415	-22,772,116	0	-22,772,116	0	9.00
10.00	Total (line 8 minus line 9)	58,272,617	25,821,452	0	25,821,452	51,625	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	948,070	0	1.00
2.00	Land Improvements	4,148,030	0	2.00
3.00	Buildings and Fixtures	25,904,891	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,429,922	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,430,913	0	8.00
9.00	Reconciling Items	-28,611,531	0	9.00
10.00	Total (line 8 minus line 9)	84,042,444	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2020 1:37 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	2,732,690	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,138,416	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,871,106	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,732,690		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,138,416		2.00
3.00	Total (sum of lines 1-2)	0	3,871,106		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2020 1:37 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	31,000,991	0	31,000,991	0.559273	12,557	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,429,922	0	24,429,922	0.440727	9,896	2.00
3.00	Total (sum of lines 1-2)	55,430,913	0	55,430,913	1.000000	22,453	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	12,557	1,407,158	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	9,896	1,230,016	0	2.00
3.00	Total (sum of lines 1-2)	0	0	22,453	2,637,174	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	12,557	0	10,078	1,429,793	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,896	0	0	1,239,912	2.00
3.00	Total (sum of lines 1-2)	0	22,453	0	10,078	2,669,705	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/26/2020 1:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-610,158	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-61,393	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-7,453	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,430	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,933	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-10,401	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,656,337			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	327,333			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-177,959	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,835	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-1,340,414	CAP REL COSTS-BLDG & FIXT	1.00	9	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	A	-767,797	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-7,130	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/26/2020 1:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - EKG	B	-528	ELECTROCARDIOLOGY	69.00	0	33.01
33.02	PROVIDER TAX	A	-1,272,278	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING EXPENSE	A	-76,671	ADMINISTRATIVE & GENERAL	5.00	0	33.03
34.00	LOBBYING EXPENSE	A	-18,766	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	PHYSICIAN LOAN FORGIVENESS	A	-4,425	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	LOSS ON BOND REFUNDING	A	108,180	CAP REL COSTS-BLDG & FIXT	1.00	14	35.00
36.00	MUTUAL FUND FEES	A	25,422	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	457B PLAN EXPENSES	A	18,347	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,546,626				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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2020 1:37 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	1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	14,569	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	1,110	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	313	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	90,490	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	7,453	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	1,738,904	1,236,276	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2,517,142	2,806,372	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	9,441	9,441	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,379,422	4,052,089	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	MEMORIAL HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1339	Period: From 10/01/2018 To 09/30/2019	Worksheet A-8-1 Date/Time Prepared: 2/26/2020 1:37 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	14,569	9		1.00
2.00	1,110	9		2.00
3.00	313	9		3.00
4.00	90,490	9		4.00
4.01	7,453	0		4.01
4.02	502,628	0		4.02
4.03	-289,230	0		4.03
4.04	0	0		4.04
5.00	327,333			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	MANAGEMENT HO		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2020 1:37 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	30.00	ADULTS & PEDIATRICS	222,000	222,000	0	0	0	1.00
2.00	50.00	OPERATING ROOM	29,646	29,646	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	55,832	55,832	0	0	0	3.00
4.00	91.00	EMERGENCY	2,605,794	2,348,859	256,935	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,913,272	2,656,337	256,935		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	222,000		1.00
2.00	50.00	OPERATING ROOM	0	0	0	29,646		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	55,832		3.00
4.00	91.00	EMERGENCY	0	0	0	2,348,859		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,656,337		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,429,793	1,429,793				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,239,912		1,239,912			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,652,717	3,658	0	4,656,375		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,059,846	244,350	409,587	741,583	7,455,366	5.00
7.00	00700	OPERATION OF PLANT	1,763,264	460,916	52,993	241,027	2,518,200	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	152,293	7,942	0	5,830	166,065	8.00
9.00	00900	HOUSEKEEPING	454,230	28,982	1,736	117,199	602,147	9.00
10.00	01000	DIETARY	214,120	55,418	2,186	33,883	305,607	10.00
11.00	01100	CAFETERIA	417,442	21,296	6,081	94,218	539,037	11.00
13.00	01300	NURSING ADMINISTRATION	821,999	37,462	5,650	232,819	1,097,930	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,396	15,778	34,493	49,650	361,317	14.00
15.00	01500	PHARMACY	524,409	10,384	12,362	141,971	689,126	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	512,773	35,593	1,252	148,420	698,038	16.00
17.00	01700	SOCIAL SERVICE	68,247	2,636	0	19,893	90,776	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,746,473	128,826	41,252	734,598	3,651,149	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,058,672	79,085	174,030	178,648	1,490,435	50.00
53.00	05300	ANESTHESIOLOGY	181,765	7,554	39,817	0	229,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,910,343	59,552	350,779	370,207	2,690,881	54.00
60.00	06000	LABORATORY	1,994,625	30,313	57,889	262,164	2,344,991	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	575,232	35,937	16,478	162,145	789,792	65.00
66.00	06600	PHYSICAL THERAPY	1,235,904	31,054	8,367	347,600	1,622,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	323,657	9,185	0	92,732	425,574	67.00
68.00	06800	SPEECH PATHOLOGY	136,698	2,759	0	38,922	178,379	68.00
69.00	06900	ELECTROCARDIOLOGY	204,883	11,071	5,300	55,785	277,039	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	123,844	0	0	0	123,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	358,750	0	0	0	358,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,112,128	0	0	0	1,112,128	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	349,924	13,813	0	57,992	421,729	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,295,141	73,091	19,660	529,089	2,916,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,180,480	1,406,655	1,239,912	4,656,375	33,157,342	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,562	0	0	5,562	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	252	17,576	0	0	17,828	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,180,732	1,429,793	1,239,912	4,656,375	33,180,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,455,366					5.00
7.00	00700	OPERATION OF PLANT	729,789	3,247,989				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,127	35,784	249,976			8.00
9.00	00900	HOUSEKEEPING	174,506	130,585	4,849	912,087		9.00
10.00	01000	DIETARY	88,567	249,693	1,992	1,384	647,243	10.00
11.00	01100	CAFETERIA	156,216	95,953	5,539	9,688	0	11.00
13.00	01300	NURSING ADMINISTRATION	318,187	168,792	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,712	71,091	777	9,688	0	14.00
15.00	01500	PHARMACY	199,713	46,785	0	8,027	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	202,296	160,372	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	26,307	11,875	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,058,125	580,445	121,225	335,771	647,243	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	431,937	356,329	19,395	98,544	0	50.00
53.00	05300	ANESTHESIOLOGY	66,405	34,036	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	779,833	268,319	18,620	53,147	0	54.00
60.00	06000	LABORATORY	679,592	136,582	384	62,282	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	228,886	161,921	0	13,287	0	65.00
66.00	06600	PHYSICAL THERAPY	470,333	139,918	16,582	20,484	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,334	41,384	0	6,090	0	67.00
68.00	06800	SPEECH PATHOLOGY	51,695	12,431	0	7,751	0	68.00
69.00	06900	ELECTROCARDIOLOGY	80,288	49,883	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,891	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,968	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	322,301	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	122,220	62,234	0	19,930	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	845,359	329,323	60,613	235,842	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,448,587	3,143,735	249,976	881,915	647,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,612	25,061	0	7,197	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,167	79,193	0	22,975	0	192.00
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)	7,455,366	3,247,989	249,976	912,087	647,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	806,433					11.00
13.00	01300	NURSING ADMINISTRATION	44,313	1,629,222				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,746	12,081	576,412			14.00
15.00	01500	PHARMACY	23,440	93,530	755	1,061,376		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,344	0	0	0	1,115,050	16.00
17.00	01700	SOCIAL SERVICE	4,739	18,882	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	184,379	752,187	40,496	0	327,105	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,080	155,928	118,582	0	74,807	50.00
53.00	05300	ANESTHESIOLOGY	10,900	43,471	2,492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,150	0	21,026	0	82,923	54.00
60.00	06000	LABORATORY	65,244	0	194,336	0	100,213	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	38,151	0	1,032	0	23,289	65.00
66.00	06600	PHYSICAL THERAPY	67,002	0	1,748	0	6,352	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,304	0	421	0	1,764	67.00
68.00	06800	SPEECH PATHOLOGY	7,464	0	346	0	706	68.00
69.00	06900	ELECTROCARDIOLOGY	11,552	0	968	0	18,349	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	39,187	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	113,515	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,061,376	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	14,672	58,570	55	0	10,939	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	123,953	494,573	41,396	0	455,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	806,433	1,629,222	576,355	1,061,376	1,101,641	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	57	0	13,409	192.00
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)	806,433	1,629,222	576,412	1,061,376	1,115,050	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	152,579					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	152,579	0	7,850,704	-370,279	7,480,425	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,785,037	521	2,785,558	50.00
53.00	05300	ANESTHESIOLOGY	0	0	386,440	0	386,440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,999,899	0	3,999,899	54.00
60.00	06000	LABORATORY	0	0	3,583,624	0	3,583,624	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	344,824	344,824	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,256,358	0	1,256,358	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,345,344	0	2,345,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	613,871	0	613,871	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	258,772	0	258,772	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	438,079	0	438,079	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	198,922	0	198,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	576,233	0	576,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,495,805	0	2,495,805	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	710,349	0	710,349	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	13,118	13,118	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	5,503,234	11,815	5,515,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,579	0	33,002,671	0	33,002,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	39,432	0	39,432	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	138,629	0	138,629	192.00
200.00		Cross Foot Adjustments		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)	152,579	0	33,180,732	0	33,180,731	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,658	0	3,658	3,658	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	42,241	244,350	409,587	696,178	585	5.00
7.00	00700	OPERATION OF PLANT	0	460,916	52,993	513,909	189	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,942	0	7,942	5	8.00
9.00	00900	HOUSEKEEPING	0	28,982	1,736	30,718	92	9.00
10.00	01000	DIETARY	18,872	55,418	2,186	76,476	27	10.00
11.00	01100	CAFETERIA	53,711	21,296	6,081	81,088	74	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,462	5,650	43,112	183	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,876	15,778	34,493	52,147	39	14.00
15.00	01500	PHARMACY	0	10,384	12,362	22,746	111	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,593	1,252	36,845	116	16.00
17.00	01700	SOCIAL SERVICE	0	2,636	0	2,636	16	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,444	128,826	41,252	186,522	576	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139	79,085	174,030	253,254	140	50.00
53.00	05300	ANESTHESIOLOGY	0	7,554	39,817	47,371	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,552	350,779	410,331	290	54.00
60.00	06000	LABORATORY	0	30,313	57,889	88,202	206	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,309	35,937	16,478	57,724	127	65.00
66.00	06600	PHYSICAL THERAPY	0	31,054	8,367	39,421	273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,185	0	9,185	73	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,759	0	2,759	31	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,071	5,300	16,371	44	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,813	0	13,813	46	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	73,091	19,660	92,751	415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,592	1,406,655	1,239,912	2,785,159	3,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,562	0	5,562	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,576	0	17,576	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	138,592	1,429,793	1,239,912	2,808,297	3,658	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	696,763					5.00
7.00	00700	OPERATION OF PLANT	68,205	582,303				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,498	6,415	18,860			8.00
9.00	00900	HOUSEKEEPING	16,309	23,411	366	70,896		9.00
10.00	01000	DIETARY	8,277	44,765	150	108	129,803	10.00
11.00	01100	CAFETERIA	14,600	17,203	418	753	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,737	30,261	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,786	12,745	59	753	0	14.00
15.00	01500	PHARMACY	18,665	8,388	0	624	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,906	28,752	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,459	2,129	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,883	104,063	9,146	26,100	129,803	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,368	63,883	1,463	7,660	0	50.00
53.00	05300	ANESTHESIOLOGY	6,206	6,102	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,883	48,105	1,405	4,131	0	54.00
60.00	06000	LABORATORY	63,514	24,487	29	4,841	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,392	29,029	0	1,033	0	65.00
66.00	06600	PHYSICAL THERAPY	43,957	25,085	1,251	1,592	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,527	7,419	0	473	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,831	2,229	0	602	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,504	8,943	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,354	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,717	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,122	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,423	11,157	0	1,549	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	79,006	59,041	4,573	18,332	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	696,129	563,612	18,860	68,551	129,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	151	4,493	0	559	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	483	14,198	0	1,786	0	192.00
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)	696,763	582,303	18,860	70,896	129,803	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	114,136					11.00
13.00	01300	NURSING ADMINISTRATION	6,272	109,565				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,370	812	78,711			14.00
15.00	01500	PHARMACY	3,317	6,290	103	60,244		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,691	0	0	0	92,310	16.00
17.00	01700	SOCIAL SERVICE	671	1,270	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,096	50,585	5,530	0	27,080	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,531	10,486	16,193	0	6,193	50.00
53.00	05300	ANESTHESIOLOGY	1,543	2,923	340	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,051	0	2,871	0	6,865	54.00
60.00	06000	LABORATORY	9,234	0	26,538	0	8,296	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,400	0	141	0	1,928	65.00
66.00	06600	PHYSICAL THERAPY	9,483	0	239	0	526	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,166	0	57	0	146	67.00
68.00	06800	SPEECH PATHOLOGY	1,056	0	47	0	58	68.00
69.00	06900	ELECTROCARDIOLOGY	1,635	0	132	0	1,519	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,351	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,501	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,244	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,077	3,939	7	0	906	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,543	33,260	5,653	0	37,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,136	109,565	78,703	60,244	91,200	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8	0	1,110	192.00
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)	114,136	109,565	78,711	60,244	92,310	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	9,181					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,181		673,565	0	673,565	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		405,171	0	405,171	50.00
53.00	05300	ANESTHESIOLOGY	0		64,485	0	64,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		558,932	0	558,932	54.00
60.00	06000	LABORATORY	0		225,347	0	225,347	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		116,774	0	116,774	65.00
66.00	06600	PHYSICAL THERAPY	0		121,827	0	121,827	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		31,046	0	31,046	67.00
68.00	06800	SPEECH PATHOLOGY	0		11,613	0	11,613	68.00
69.00	06900	ELECTROCARDIOLOGY	0		36,148	0	36,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		8,705	0	8,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		25,218	0	25,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		90,366	0	90,366	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		44,917	0	44,917	76.00
76.01	03950	DIABETIC EDUCATION	0		0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		348,257	0	348,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,181	0	2,762,371	0	2,762,371	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		10,765	0	10,765	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		35,161	0	35,161	192.00
200.00		Cross Foot Adjustments		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)	9,181	0	2,808,297	0	2,808,297	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	162,207					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,230,016				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	415	0	14,912,083			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,721	406,318	2,374,922	-7,455,366	25,725,366	5.00
7.00	00700	OPERATION OF PLANT	52,290	52,570	771,892	0	2,518,200	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	0	18,672	0	166,065	8.00
9.00	00900	HOUSEKEEPING	3,288	1,722	375,331	0	602,147	9.00
10.00	01000	DIETARY	6,287	2,169	108,510	0	305,607	10.00
11.00	01100	CAFETERIA	2,416	6,032	301,733	0	539,037	11.00
13.00	01300	NURSING ADMINISTRATION	4,250	5,605	745,606	0	1,097,930	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	34,218	159,004	0	361,317	14.00
15.00	01500	PHARMACY	1,178	12,263	454,665	0	689,126	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	1,242	475,318	0	698,038	16.00
17.00	01700	SOCIAL SERVICE	299	0	63,706	0	90,776	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	40,923	2,352,557	0	3,651,149	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	172,641	572,123	0	1,490,435	50.00
53.00	05300	ANESTHESIOLOGY	857	39,499	0	0	229,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,756	347,980	1,185,592	0	2,690,881	54.00
60.00	06000	LABORATORY	3,439	57,427	839,582	0	2,344,991	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,077	16,346	519,270	0	789,792	65.00
66.00	06600	PHYSICAL THERAPY	3,523	8,300	1,113,193	0	1,622,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,042	0	296,976	0	425,574	67.00
68.00	06800	SPEECH PATHOLOGY	313	0	124,647	0	178,379	68.00
69.00	06900	ELECTROCARDIOLOGY	1,256	5,258	178,651	0	277,039	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	123,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	358,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,112,128	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,567	0	185,719	0	421,729	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,292	19,503	1,694,414	0	2,916,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,582	1,230,016	14,912,083	-7,455,366	25,701,976	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	631	0	0	0	5,562	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	0	0	0	17,828	192.00
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)	1,429,793	1,239,912	4,656,375		7,455,366	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.814620	1.008045	0.312255		0.289806	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,658		696,763	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000245		0.027085	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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	81,781					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	212,757				8.00
9.00	00900	HOUSEKEEPING	3,288	4,127	3,295			9.00
10.00	01000	DIETARY	6,287	1,695	5	22,239		10.00
11.00	01100	CAFETERIA	2,416	4,714	35	0	40,838	11.00
13.00	01300	NURSING ADMINISTRATION	4,250	0	0	0	2,244	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	661	35	0	848	14.00
15.00	01500	PHARMACY	1,178	0	29	0	1,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	0	0	0	2,752	16.00
17.00	01700	SOCIAL SERVICE	299	0	0	0	240	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	103,177	1,213	22,239	9,337	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	16,507	356	0	1,979	50.00
53.00	05300	ANESTHESIOLOGY	857	0	0	0	552	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,756	15,848	192	0	4,312	54.00
60.00	06000	LABORATORY	3,439	327	225	0	3,304	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,077	0	48	0	1,932	65.00
66.00	06600	PHYSICAL THERAPY	3,523	14,113	74	0	3,393	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,042	0	22	0	775	67.00
68.00	06800	SPEECH PATHOLOGY	313	0	28	0	378	68.00
69.00	06900	ELECTROCARDIOLOGY	1,256	0	0	0	585	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,567	0	72	0	743	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,292	51,588	852	0	6,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,156	212,757	3,186	22,239	40,838	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	631	0	26	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	0	83	0	0	192.00
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)	3,247,989	249,976	912,087	647,243	806,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.715692	1.174937	276.809408	29.103962	19.747123	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	582,303	18,860	70,896	129,803	114,136	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.120272	0.088646	21.516237	5.836728	2.794848	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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	183,006					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,357	1,821,672				14.00
15.00	01500	PHARMACY	10,506	2,387	1,112,128			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,160		16.00
17.00	01700	SOCIAL SERVICE	2,121	0	0	0	2,121	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,491	127,981	0	927	2,121	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,515	374,763	0	212	0	50.00
53.00	05300	ANESTHESIOLOGY	4,883	7,876	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,449	0	235	0	54.00
60.00	06000	LABORATORY	0	614,179	0	284	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,262	0	66	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,524	0	18	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,329	0	5	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,092	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,058	0	52	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	123,844	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	358,750	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,112,128	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,579	173	0	31	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,554	130,826	0	1,290	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	183,006	1,821,493	1,112,128	3,122	2,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	179	0	38	0	192.00
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)	1,629,222	576,412	1,061,376	1,115,050	152,579	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.902561	0.316419	0.954365	352.863924	71.937294	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	109,565	78,711	60,244	92,310	9,181	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.598696	0.043208	0.054170	29.212025	4.328619	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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/26/2020 1:37 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	DIABETIC EDUCATION	0	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	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
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-2 | Date/Time Prepared: 2/26/2020 1:37 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY & ANCILLARIES	1	30.00	-357,161	7.00
8.00		ANCILLARIES	1	50.00	521	8.00
9.00		IV THERAPY	1	64.00	344,824	9.00
10.00		ANCILLARIES	1	91.00	11,815	10.00
11.00		DIABETIC EDUCATION	1	30.00	-13,118	11.00
12.00		DIABETIC EDUCATION	1	76.01	13,118	12.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,480,425		7,480,425	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,785,558		2,785,558	0	0	50.00
53.00	05300	ANESTHESIOLOGY	386,440		386,440	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,999,899		3,999,899	0	0	54.00
60.00	06000	LABORATORY	3,583,624		3,583,624	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	344,824		344,824	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,256,358	0	1,256,358	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,345,344	0	2,345,344	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	613,871	0	613,871	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	258,772	0	258,772	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	438,079		438,079	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	198,922		198,922	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	576,233		576,233	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,495,805		2,495,805	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	710,349		710,349	0	0	76.00
76.01	03950	DIABETIC EDUCATION	13,118		13,118	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,515,049		5,515,049	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	372,211		372,211		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,374,881	0	33,374,881	0	0	200.00
201.00		Less Observation Beds	372,211		372,211		0	201.00
202.00		Total (see instructions)	33,002,670	0	33,002,670	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,833,546		5,833,546			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	365,587	3,573,115	3,938,702	0.707227	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	135,747	627,593	763,340	0.506249	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,019,856	35,582,387	37,602,243	0.106374	0.000000	54.00
60.00	06000	LABORATORY	2,250,071	11,705,294	13,955,365	0.256792	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	16,522	2,036,389	2,052,911	0.167968	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,365,465	2,411,663	3,777,128	0.332623	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	769,695	3,956,740	4,726,435	0.496218	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	844,639	560,801	1,405,440	0.436782	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	259,846	676,041	935,887	0.276499	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	160,671	2,171,772	2,332,443	0.187820	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	506,626	516,654	1,023,280	0.194396	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	919,487	1,406,635	2,326,122	0.247723	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,861,758	6,356,518	8,218,276	0.303690	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	638,930	638,930	1.111779	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	19,561	14,637	34,198	0.383590	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	182,406	14,871,463	15,053,869	0.366354	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,013,122	1,013,122	0.367390	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,511,483	88,119,754	105,631,237			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,511,483	88,119,754	105,631,237			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/26/2020 1:37 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	405,171	3,938,702	0.102869	221,511	22,787	50.00
53.00	05300	ANESTHESIOLOGY	64,485	763,340	0.084477	84,045	7,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,932	37,602,243	0.014864	1,155,729	17,179	54.00
60.00	06000	LABORATORY	225,347	13,955,365	0.016148	1,135,003	18,328	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,052,911	0.000000	1,756	0	64.00
65.00	06500	RESPIRATORY THERAPY	116,774	3,777,128	0.030916	638,893	19,752	65.00
66.00	06600	PHYSICAL THERAPY	121,827	4,726,435	0.025776	101,566	2,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,046	1,405,440	0.022090	107,226	2,369	67.00
68.00	06800	SPEECH PATHOLOGY	11,613	935,887	0.012409	55,901	694	68.00
69.00	06900	ELECTROCARDIOLOGY	36,148	2,332,443	0.015498	74,788	1,159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,705	1,023,280	0.008507	237,466	2,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,218	2,326,122	0.010841	536,611	5,817	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,366	8,218,276	0.010996	722,809	7,948	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	44,917	638,930	0.070300	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	34,198	0.000000	3,519	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	348,257	15,053,869	0.023134	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,515	1,013,122	0.033081	0	0	92.00
200.00		Total (lines 50 through 199)	2,122,321	99,797,691		5,076,823	107,771	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/26/2020 1:37 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,938,702	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	763,340	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,602,243	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,955,365	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,052,911	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,777,128	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,726,435	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,405,440	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	935,887	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,332,443	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,023,280	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,326,122	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,218,276	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	638,930	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	34,198	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	15,053,869	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,013,122	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	99,797,691		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	221,511	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	84,045	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,155,729	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,135,003	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,756	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	638,893	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	101,566	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	107,226	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	55,901	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	74,788	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	237,466	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	536,611	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	722,809	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	3,519	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,076,823	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.707227	0	1,643,407	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.506249	0	218,852	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106374	0	13,976,216	0	0	54.00
60.00	06000	LABORATORY	0.256792	0	4,573,119	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167968	0	1,017,909	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	0	1,041,165	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.496218	0	1,426,596	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436782	0	196,982	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.276499	0	40,361	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187820	0	1,004,266	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194396	0	192,328	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247723	0	741,896	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303690	0	3,908,756	6,438	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.111779	0	548,877	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.383590	0	14,637	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.366354	0	4,427,590	1,534	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.367390	0	593,493	0	0	92.00
200.00		Subtotal (see instructions)		0	35,566,450	7,972	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	35,566,450	7,972	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,162,262	0		50.00
53.00	05300	ANESTHESIOLOGY	110,794	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,486,706	0		54.00
60.00	06000	LABORATORY	1,174,340	0		60.00
64.00	06400	INTRAVENOUS THERAPY	170,976	0		64.00
65.00	06500	RESPIRATORY THERAPY	346,315	0		65.00
66.00	06600	PHYSICAL THERAPY	707,903	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	86,038	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,160	0		68.00
69.00	06900	ELECTROCARDIOLOGY	188,621	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,388	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	183,785	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,187,050	1,955		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	610,230	0		76.00
76.01	03950	DIABETIC EDUCATION	5,615	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,622,065	562		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	218,043	0		92.00
200.00		Subtotal (see instructions)	9,309,291	2,517		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,309,291	2,517		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.707227	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.506249	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106374	0	0	0	0	54.00
60.00	06000	LABORATORY	0.256792	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167968	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.496218	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436782	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.276499	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187820	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194396	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247723	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303690	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.111779	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.383590	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.366354	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.367390	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03950	DIABETIC EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,232	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,408	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)	2,155	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	665	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)	1,994	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	41	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)	124	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,653	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)	505	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)	1,515	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	157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,480,425	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)	6,445	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)	19,492	25.00
26.00	Total swing-bed cost (see instructions)	3,937,805	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,542,620	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)	3,542,620	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)	1,471.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,431,861	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)	2,431,861	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	1,353,103	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,784,964	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)	742,946	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	2,228,838	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,971,784	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)	253	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,471.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	372,211	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/26/2020 1:37 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	673,565	7,480,425	0.090044	372,211	33,515	90.00
91.00	Nursing School cost	0	7,480,425	0.000000	372,211	0	91.00
92.00	Allied health cost	0	7,480,425	0.000000	372,211	0	92.00
93.00	All other Medical Education	0	7,480,425	0.000000	372,211	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,545,949		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.707227	221,511	156,659	50.00
53.00	05300	ANESTHESIOLOGY	0.506249	84,045	42,548	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106374	1,155,729	122,940	54.00
60.00	06000	LABORATORY	0.256792	1,135,003	291,460	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167968	1,756	295	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	638,893	212,511	65.00
66.00	06600	PHYSICAL THERAPY	0.496218	101,566	50,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436782	107,226	46,834	67.00
68.00	06800	SPEECH PATHOLOGY	0.276499	55,901	15,457	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187820	74,788	14,047	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194396	237,466	46,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247723	536,611	132,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303690	722,809	219,510	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.111779	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.383590	3,519	1,350	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.366354	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.367390	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,076,823	1,353,103	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)		5,076,823		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/26/2020 1:37 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.707227	7,251	5,128	50.00
53.00	05300	ANESTHESIOLOGY	0.506249	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106374	233,244	24,811	54.00
60.00	06000	LABORATORY	0.256792	483,617	124,189	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167968	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	340,990	113,421	65.00
66.00	06600	PHYSICAL THERAPY	0.496218	484,923	240,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436782	529,894	231,448	67.00
68.00	06800	SPEECH PATHOLOGY	0.276499	135,649	37,507	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187820	10,204	1,917	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194396	110,547	21,490	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247723	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303690	578,758	175,763	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.111779	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.383590	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.366354	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.367390	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,915,077	976,302	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)		2,915,077		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/26/2020 1:37 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,311,808	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,311,808	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,404,926	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)	64,011	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,191,111	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)	3,149,804	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)	3,149,804	30.00
31.00	Primary payer payments	307	31.00
32.00	Subtotal (line 30 minus line 31)	3,149,497	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)	1,121,816	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	729,180	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	991,369	36.00
37.00	Subtotal (see instructions)	3,878,677	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,878,677	40.00
40.01	Sequestration adjustment (see instructions)	77,574	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,948,855	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,147,752	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2020 1:37 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,394,597		4,886,360	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	04/11/2019	215,581	04/11/2019	62,495	3.01
3.02		09/03/2019	108,727		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)		324,308		62,495	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)		3,718,905		4,948,855	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		343,323		1,147,752	6.02
7.00	Total Medicare program liability (see instructions)		3,375,582		3,801,103	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: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2020 1:37 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		3,675,301		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	04/11/2019	162,744		0	3.01
3.02		09/03/2019	59,808		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)		222,552		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)		3,897,853		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		70,002		0	6.02
7.00	Total Medicare program liability (see instructions)		3,827,851		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: 14-1339	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/26/2020 1:37 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: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-2 | Date/Time Prepared: 2/26/2020 1:37 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)	3,001,502	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	986,065	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,020	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)	3,987,567	0	8.00
9.00	Primary payer payments (see instructions)	12,447	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,975,120	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)	3,975,120	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	69,150	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	3,905,970	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)	3,905,970	0	19.00
19.01	Sequestration adjustment (see instructions)	78,119	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	3,897,853	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-70,002	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/26/2020 1:37 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,784,964	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)	3,784,964	4.00
5.00	Primary payer payments	2,516	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,820,298	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)	3,820,298	19.00
20.00	Deductibles (exclude professional component)	438,628	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,381,670	22.00
23.00	Coinsurance	4,092	23.00
24.00	Subtotal (line 22 minus line 23)	3,377,578	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	102,912	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	66,893	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	87,311	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,444,471	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)	3,444,471	30.00
30.01	Sequestration adjustment (see instructions)	68,889	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,718,905	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-343,323	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G | Date/Time Prepared: 2/26/2020 1:37 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	6,997,837	0	0	0	1.00
2.00	Temporary investments	298,006	0	0	0	2.00
3.00	Notes receivable	6,952,852	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	415,573	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,808,665	0	0	0	6.00
7.00	Inventory	385,929	0	0	0	7.00
8.00	Prepaid expenses	495,686	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	699,444	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,436,662	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	948,070	0	0	0	12.00
13.00	Land improvements	4,162,150	0	0	0	13.00
14.00	Accumulated depreciation	-1,831,739	0	0	0	14.00
15.00	Buildings	25,904,891	0	0	0	15.00
16.00	Accumulated depreciation	-14,438,499	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,429,922	0	0	0	23.00
24.00	Accumulated depreciation	-22,583,505	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	28,597,411	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	45,188,701	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	35,864,281	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	3,509,512	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,373,793	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	98,999,156	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,217,289	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,648,653	0	0	0	38.00
39.00	Payroll taxes payable	48	0	0	0	39.00
40.00	Notes and loans payable (short term)	455,470	0	0	0	40.00
41.00	Deferred income	524,563	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,152,054	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,998,077	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,552,642	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	651,590	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,204,232	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,202,309	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	70,796,847				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)	70,796,847	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	98,999,156	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-1 | Date/Time Prepared: 2/26/2020 1:37 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		61,080,017		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,716,830				2.00
3.00	Total (sum of line 1 and line 2)		70,796,847		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)		70,796,847		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,796,847		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2020 1:37 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,459,713		3,459,713	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,255,922		2,255,922	5.00
6.00	Swing bed - NF	139,988		139,988	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)	5,855,623		5,855,623	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)	5,855,623		5,855,623	17.00
18.00	Ancillary services	11,592,925	73,927,851	85,520,776	18.00
19.00	Outpatient services	178,419	16,062,302	16,240,721	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	195,294	9,110,503	9,305,797	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,822,261	99,100,656	116,922,917	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,727,358		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)		39,727,358		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-3 | Date/Time Prepared: 2/26/2020 1:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	116,922,917	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,998,937	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,923,980	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,727,358	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,196,622	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	74,678	6.00
7.00	Income from investments	1,370,781	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	1,430	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	162,667	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	18,832	24.00
24.01	OTHER (SPECIFY)	0	24.01
25.00	Total other income (sum of lines 6-24)	1,628,388	25.00
26.00	Total (line 5 plus line 25)	9,825,010	26.00
27.00	LOSS ON BOND REFUNDING	108,180	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	108,180	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,716,830	29.00