

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: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/26/2020 1:26 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 2/26/2020 Time: 1:26 pm
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (14-1322) 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.

☒ 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 GOLDSEBERRY-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		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-511,126	-540,547	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	-547,494	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-1,058,620	-540,547	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1322		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 1:26 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 200 STAHLHUT DRIVE			PO Box:				1.00		
2.00	City: LINCOLN			State: IL		Zip Code: 62656		County: LOGAN		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018	09/30/2019		
21.00	Type of Control (see instructions)						2			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0				
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1322

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	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	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	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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	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
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N
				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.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	30,331	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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: 14-1322		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 1:26 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 HELATH SYSTEM	Contractor's Name: NGS		Contractor's Number: 00131						
142.00	Street: 701 NORTH FIRST STREET	PO Box:								
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62781						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	N	157.00			
158.00	SUBPROVIDER						158.00			
159.00	SNF	N	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00			
161.00	CMHC		N	N	N	N	161.00			
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 1:26 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/26/2019	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 1:26 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		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.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 1:26 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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 1:26 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	70,671.00	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	70,671.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	70,671.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 1:26 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)	1,286	80	2,500			1.00
2.00	HMO and other (see instructions)	131	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	1,344	0	1,793			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	97			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,630	80	4,390			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		55	301			13.00
14.00	Total (see instructions)	2,630	135	4,691	0.00	288.08	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	288.08	27.00
28.00	Observation Bed Days		6	356			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			58			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	56			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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 1:26 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	343	27	759	1.00
2.00 HMO and other (see instructions)			30	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	343	27	759	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: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/26/2020 1:26 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)		0.289047		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,526,220		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		2,639,772		5.00
6.00	Medicaid charges		29,277,560		6.00
7.00	Medicaid cost (line 1 times line 6)		8,462,591		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)		3,296,599		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		34,843		9.00
10.00	Stand-alone CHIP charges		273,119		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		78,944		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		44,101		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)		3,340,700		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,180,532	117,979	2,298,511	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	630,276	117,979	748,255	21.00
22.00	Payments received from patients for amounts previously written off as charity care	81,920	0	81,920	22.00
23.00	Cost of charity care (line 21 minus line 22)	548,356	117,979	666,335	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)		2,665,786		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		725,497		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,116,148		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,549,638		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		838,569		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,504,904		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,845,604		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,730,622	2,730,622	1,119,617	3,850,239
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,317,495	1,317,495	46,520	1,364,015
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	645,166	5,641,769	6,286,935	-146,434	6,140,501
5.00	00500	ADMINISTRATIVE & GENERAL	2,351,750	5,039,584	7,391,334	-46,336	7,344,998
7.00	00700	OPERATION OF PLANT	666,107	706,249	1,372,356	0	1,372,356
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	217,053	217,053
9.00	00900	HOUSEKEEPING	418,824	250,327	669,151	-217,053	452,098
10.00	01000	DIETARY	624,978	427,440	1,052,418	-630,206	422,212
11.00	01100	CAFETERIA	0	0	0	628,369	628,369
13.00	01300	NURSING ADMINISTRATION	460,668	42,483	503,151	-217,783	285,368
14.00	01400	CENTRAL SERVICES & SUPPLY	260,777	241,241	502,018	-239,950	262,068
15.00	01500	PHARMACY	505,380	1,229,986	1,735,366	-1,220,561	514,805
16.00	01600	MEDICAL RECORDS & LIBRARY	581,508	91,991	673,499	0	673,499
17.00	01700	SOCIAL SERVICE	0	0	0	206,491	206,491
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,018,554	0	1,018,554	146,434	1,164,988
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,776,164	1,891,256	3,667,420	732,194	4,399,614
43.00	04300	NURSERY	0	0	0	155,115	155,115
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	834,644	590,404	1,425,048	-43,292	1,381,756
52.00	05200	DELIVERY ROOM & LABOR ROOM	838,264	266,783	1,105,047	-887,309	217,738
53.00	05300	ANESTHESIOLOGY	0	250,609	250,609	0	250,609
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,487,027	655,263	2,142,290	-33,863	2,108,427
60.00	06000	LABORATORY	960,175	1,184,370	2,144,545	0	2,144,545
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	465,957	36,209	502,166	0	502,166
66.00	06600	PHYSICAL THERAPY	1,459,979	76,189	1,536,168	0	1,536,168
67.00	06700	OCCUPATIONAL THERAPY	161,682	3,130	164,812	0	164,812
68.00	06800	SPEECH PATHOLOGY	72,989	520	73,509	0	73,509
69.00	06900	ELECTROCARDIOLOGY	166,991	53,039	220,030	0	220,030
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	157,643	157,643
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	125,644	125,644
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,272,288	1,272,288
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	164,659	64,259	228,918	0	228,918
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	175,245	17,638	192,883	0	192,883
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,527,599	3,167,335	4,694,934	-4,780	4,690,154
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		1,119,801	1,119,801	-1,119,801	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,625,087	27,095,992	44,721,079	0	44,721,079
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	17,625,087	27,095,992	44,721,079	0	44,721,079

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/26/2020 1:26 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	-1,001,373	2,848,866	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	24,766	1,388,781	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,889	6,148,390	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,551,590	5,793,408	5.00
7.00	00700	OPERATION OF PLANT	0	1,372,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	217,053	8.00
9.00	00900	HOUSEKEEPING	0	452,098	9.00
10.00	01000	DIETARY	0	422,212	10.00
11.00	01100	CAFETERIA	-169,497	458,872	11.00
13.00	01300	NURSING ADMINISTRATION	0	285,368	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	262,068	14.00
15.00	01500	PHARMACY	0	514,805	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-158	673,341	16.00
17.00	01700	SOCIAL SERVICE	0	206,491	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,164,988	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,312,901	3,086,713	30.00
43.00	04300	NURSERY	0	155,115	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-33,838	1,347,918	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-54,900	162,838	52.00
53.00	05300	ANESTHESIOLOGY	0	250,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,108,427	54.00
60.00	06000	LABORATORY	-2,931	2,141,614	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	502,166	65.00
66.00	06600	PHYSICAL THERAPY	-40,586	1,495,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	164,812	67.00
68.00	06800	SPEECH PATHOLOGY	0	73,509	68.00
69.00	06900	ELECTROCARDIOLOGY	-55,510	164,520	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	157,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	125,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,272,288	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	228,918	76.00
76.01	03950	DIABETIC EDUCATION	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	192,883	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,583,726	2,106,428	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)	-7,939,343	36,781,736	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,939,343	36,781,736	200.00

RECLASSIFICATIONS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/26/2020 1:26 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - STERILE PROCESSING				1.00	
	OPERATING ROOM	50.00	43,949	38,279		
	0		43,949	38,279		
1.00	B - LABOR & DELIVERY				1.00	
	ADULTS & PEDIATRICS	30.00	584,463	147,731		
	2.00	NURSERY	43.00	123,818		31,297
0			708,281	179,028	2.00	
1.00	C - CASE MANAGEMENT				1.00	
	SOCIAL SERVICE	17.00	206,491	0		
	0		206,491	0		
1.00	D - PROPERTY INSURANCE				1.00	
	OTHER CAP REL COSTS	3.00	0	46,336		
	2.00	0	0	0		
0			0	46,336	2.00	
1.00	E - DRUG EXPENSE				1.00	
	DRUGS CHARGED TO PATIENTS	73.00	0	1,272,288		
	0.00	0	0	0		
	0.00	0	0	0		
	0.00	0	0	0		
	0.00	0	0	0		
	0		0	1,272,288		
1.00	F - LAUNDRY EXPENSE				1.00	
	LAUNDRY & LINEN SERVICE	8.00	37,106	179,947		
	0		37,106	179,947		
1.00	G - IMPLANTS & MEDICAL SUPPLIES				1.00	
	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	157,643		
	2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0		125,644
	3.00	0	0	0		
0		0	283,287	3.00		
1.00	H - CAFETERIA EXPENSE				1.00	
	CAFETERIA	11.00	373,809	254,560		
	0		373,809	254,560		
1.00	I - INTEREST EXPENSE				1.00	
	CAP REL COSTS-BLDG & FIXT	1.00	0	1,085,245		
	2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		34,556
0			0	1,119,801	2.00	
1.00	K - CRNA BENEFITS				1.00	
	NONPHYSICIAN ANESTHETISTS	19.00	0	146,434		
	0		0	146,434		
500.00	Grand Total: Increases		1,369,636	3,519,960	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/26/2020 1:26 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - STERILE PROCESSING						1.00
	CENTRAL SERVICES & SUPPLY	14.00	43,949	38,279	0		
	0		43,949	38,279			
1.00	B - LABOR & DELIVERY						1.00
	DELIVERY ROOM & LABOR ROOM	52.00	708,281	179,028	0		
	0	0.00	0	0	0		
2.00			708,281	179,028			2.00
1.00	C - CASE MANAGEMENT						1.00
	NURSING ADMINISTRATION	13.00	206,491	0	0		
	0		206,491	0			
1.00	D - PROPERTY INSURANCE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	46,336	12		
	0	0.00	0	0	12		
2.00			0	46,336			2.00
1.00	E - DRUG EXPENSE						1.00
	DIETARY	10.00	0	1,837	0		
	NURSING ADMINISTRATION	13.00	0	11,292	0		
	PHARMACY	15.00	0	1,220,516	0		
	RADIOLOGY-DIAGNOSTIC	54.00	0	33,863	0		
	EMERGENCY	91.00	0	4,780	0		
	0		0	1,272,288			
1.00	F - LAUNDRY EXPENSE						1.00
	HOUSEKEEPING	9.00	37,106	179,947	0		
	0		37,106	179,947			
1.00	G - IMPLANTS & MEDICAL SUPPLIES						1.00
	CENTRAL SERVICES & SUPPLY	14.00	0	157,722	0		
	PHARMACY	15.00	0	45	0		
	OPERATING ROOM	50.00	0	125,520	0		
	0		0	283,287			
1.00	H - CAFETERIA EXPENSE						1.00
	DIETARY	10.00	373,809	254,560	0		
	0		373,809	254,560			
1.00	I - INTEREST EXPENSE						1.00
	INTEREST EXPENSE	113.00	0	1,119,801	11		
	0	0.00	0	0	11		
2.00			0	1,119,801			2.00
1.00	K - CRNA BENEFITS						1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	146,434	0		
	0		0	146,434			
500.00	Grand Total: Decreases		1,369,636	3,519,960			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/26/2020 1:26 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	1,454,817	0	0	0	0	1.00	
2.00	Land Improvements	6,071,397	6,803	0	6,803	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	42,607,743	266,470	0	266,470	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	15,464,641	791,019	0	791,019	143,712	6.00	
7.00	HIT designated Assets	1,433,236	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	67,031,834	1,064,292	0	1,064,292	143,712	8.00	
9.00	Reconciling Items	-174,853	-1,791,741	0	-1,791,741	0	9.00	
10.00	Total (line 8 minus line 9)	67,206,687	2,856,033	0	2,856,033	143,712	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,454,817	0				1.00	
2.00	Land Improvements	6,078,200	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	42,874,213	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	16,111,948	0				6.00	
7.00	HIT designated Assets	1,433,236	0				7.00	
8.00	Subtotal (sum of lines 1-7)	67,952,414	0				8.00	
9.00	Reconciling Items	-1,966,594	0				9.00	
10.00	Total (line 8 minus line 9)	69,919,008	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/26/2020 1:26 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	2,730,622	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,317,495	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,048,117	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,730,622				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,317,495				2.00
3.00	Total (sum of lines 1-2)	0	4,048,117				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/26/2020 1:26 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	50,407,230	0	50,407,230	0.741802	34,372	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,545,184	0	17,545,184	0.258198	11,964	2.00
3.00	Total (sum of lines 1-2)	67,952,414	0	67,952,414	1.000000	46,336	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	34,372	2,747,461	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	11,964	1,376,817	0	2.00
3.00	Total (sum of lines 1-2)	0	0	46,336	4,124,278	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	34,372	0	67,033	2,848,866	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,964	0	0	1,388,781	2.00
3.00	Total (sum of lines 1-2)	0	46,336	0	67,033	4,237,647	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,085,245	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-34,556	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-8,379	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,556	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-13,227	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,040,875			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	234,174			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-169,497	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	-158	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,164,988	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	A	-74,529	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INCOME - A&G	B	-5,152	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	RENTAL INCOME	B	-6,950	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INCOME - LAB	B	-2,931	LABORATORY	60.00	0	33.02
33.03	MISC INCOME - PT	B	-40,586	PHYSICAL THERAPY	66.00	0	33.03
34.00	PROVIDER TAX	A	-1,520,228	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MUTUAL FUND FEES	A	101,002	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	MARKETING - SALARIES	A	-46,059	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	MARKETING - BENEFITS	A	-9,871	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.02
35.03	MARKETING - OTHER	A	-123,557	ADMINISTRATIVE & GENERAL	5.00	0	35.03
36.00	FUNDED DEPRECIATION TRUSTEE FEES	A	10,599	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	457B PLAN EXPENSES	A	17,760	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
38.00	LOBBYING EXPENSE	A	-19,567	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	LOSS ON BOND REFUNDING	A	67,033	CAP REL COSTS-BLDG & FIXT	1.00	14	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,939,343				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: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/26/2020 1:26 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 POOLED CAPITAL - BLDG	16,380	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO POOLED CAPITAL - MME	1,248	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO POOLED CAPITAL - BLDG	459	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO DIRECT CAPITAL - MME	132,603	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	8,379	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,081,505	1,413,161	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	2,172,966	2,766,205	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	466,714	466,714	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,880,254	4,646,080	5.00

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

	Symbol (1)	Name	Percentage of Ownership	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 HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/26/2020 1:26 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	16,380	9		1.00
2.00	1,248	9		2.00
3.00	459	9		3.00
4.00	132,603	9		4.00
4.01	8,379	0		4.01
4.02	668,344	0		4.02
4.03	-593,239	0		4.03
4.04	0	0		4.04
5.00	234,174			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			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/26/2020 1:26 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	1,312,901	1,312,901	0	0	0	1.00
2.00	50.00	OPERATING ROOM	33,838	33,838	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	54,900	54,900	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	55,510	55,510	0	0	0	4.00
5.00	91.00	EMERGENCY	2,764,544	2,583,726	180,818	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			4,221,693	4,040,875	180,818		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	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	1,312,901		1.00
2.00	50.00	OPERATING ROOM	0	0	0	33,838		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	54,900		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	55,510		4.00
5.00	91.00	EMERGENCY	0	0	0	2,583,726		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	4,040,875		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,848,866	2,848,866				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,388,781		1,388,781			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,148,390	2,815	0	6,151,205		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,793,408	159,436	280,208	891,140	7,124,192	5.00
7.00	00700	OPERATION OF PLANT	1,372,356	888,891	46,712	257,448	2,565,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	217,053	13,786	0	14,341	245,180	8.00
9.00	00900	HOUSEKEEPING	452,098	77,108	0	147,532	676,738	9.00
10.00	01000	DIETARY	422,212	66,377	25,632	97,076	611,297	10.00
11.00	01100	CAFETERIA	458,872	36,785	38,147	144,476	678,280	11.00
13.00	01300	NURSING ADMINISTRATION	285,368	4,980	0	98,238	388,586	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	262,068	58,943	755	83,803	405,569	14.00
15.00	01500	PHARMACY	514,805	31,252	8,338	195,327	749,722	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	673,341	43,666	0	224,751	941,758	16.00
17.00	01700	SOCIAL SERVICE	206,491	2,502	0	79,808	288,801	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,086,713	439,934	45,681	912,376	4,484,704	30.00
43.00	04300	NURSERY	155,115	8,950	3,839	47,855	215,759	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,347,918	249,367	432,772	339,573	2,369,630	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,838	15,855	4,031	50,238	232,962	52.00
53.00	05300	ANESTHESIOLOGY	250,609	7,314	15,058	0	272,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,108,427	180,583	290,745	574,730	3,154,485	54.00
60.00	06000	LABORATORY	2,141,614	108,480	73,248	371,104	2,694,446	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	502,166	21,749	11,415	180,091	715,421	65.00
66.00	06600	PHYSICAL THERAPY	1,495,582	115,649	18,175	564,276	2,193,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,812	6,376	0	62,489	233,677	67.00
68.00	06800	SPEECH PATHOLOGY	73,509	2,598	0	28,210	104,317	68.00
69.00	06900	ELECTROCARDIOLOGY	164,520	4,306	44,080	64,541	277,447	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,643	0	0	0	157,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	125,644	0	0	0	125,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,272,288	0	0	0	1,272,288	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	228,918	40,442	0	63,640	333,000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	192,883	94,189	8,476	67,731	363,279	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,106,428	144,279	41,469	590,411	2,882,587	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)	36,781,736	2,826,612	1,388,781	6,151,205	36,759,482	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,254	0	0	22,254	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	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)	36,781,736	2,848,866	1,388,781	6,151,205	36,781,736	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 1:26 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	7,124,192					5.00
7.00	00700	OPERATION OF PLANT	616,249	3,181,656				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,896	24,398	328,474			8.00
9.00	00900	HOUSEKEEPING	162,563	136,467	0	975,768		9.00
10.00	01000	DIETARY	146,843	117,476	987	37,947	914,550	10.00
11.00	01100	CAFETERIA	162,933	65,104	1,469	21,030	0	11.00
13.00	01300	NURSING ADMINISTRATION	93,344	8,814	0	2,847	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,424	104,319	308	33,697	0	14.00
15.00	01500	PHARMACY	180,094	55,311	0	17,866	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	226,224	77,282	0	24,963	0	16.00
17.00	01700	SOCIAL SERVICE	69,374	4,428	0	1,430	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	1,077,296	778,603	98,150	251,505	899,742	30.00
43.00	04300	NURSERY	51,829	15,840	2,538	5,116	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	569,221	441,335	36,233	142,559	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,961	28,060	2,663	9,064	0	52.00
53.00	05300	ANESTHESIOLOGY	65,574	12,944	0	4,181	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	757,755	319,601	44,402	103,237	0	54.00
60.00	06000	LABORATORY	647,246	191,990	181	62,016	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	171,855	38,492	0	12,433	0	65.00
66.00	06600	PHYSICAL THERAPY	526,955	204,679	45,716	66,115	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,133	11,284	0	3,645	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,059	4,599	0	1,485	0	68.00
69.00	06900	ELECTROCARDIOLOGY	66,647	7,622	8,296	2,462	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,868	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,182	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	305,623	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	79,992	71,576	0	23,120	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	87,265	166,698	0	53,846	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	692,441	255,348	78,941	82,482	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)	7,118,846	3,142,270	319,884	963,046	899,742	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,346	39,386	0	12,722	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,590	0	14,808	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)	7,124,192	3,181,656	328,474	975,768	914,550	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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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	928,816					11.00
13.00	01300	NURSING ADMINISTRATION	14,310	507,901				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,712	0	670,029			14.00
15.00	01500	PHARMACY	27,985	0	2,573	1,033,551		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,375	0	71	0	1,333,673	16.00
17.00	01700	SOCIAL SERVICE	11,630	13,394	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	195,712	242,056	52,308	0	201,026	30.00
43.00	04300	NURSERY	7,950	9,826	698	0	21,093	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	68,372	72,103	88,288	0	138,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,359	10,316	732	0	7,351	52.00
53.00	05300	ANESTHESIOLOGY	19,217	23,788	7,828	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,717	0	39,583	0	117,931	54.00
60.00	06000	LABORATORY	87,589	0	280,467	0	119,209	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,799	0	7,111	0	20,454	65.00
66.00	06600	PHYSICAL THERAPY	98,492	0	11,544	0	16,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,131	0	558	0	1,918	67.00
68.00	06800	SPEECH PATHOLOGY	5,497	0	0	0	1,598	68.00
69.00	06900	ELECTROCARDIOLOGY	11,176	0	2,165	0	31,001	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	58,867	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	46,918	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,033,551	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,540	0	122	0	6,712	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	11,994	0	984	0	2,557	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	110,259	136,418	69,212	0	647,179	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)	928,816	507,901	670,029	1,033,551	1,333,673	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	0	0	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)	928,816	507,901	670,029	1,033,551	1,333,673	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1322

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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	389,057					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	389,057	0	8,670,159	-631,024	8,039,135	30.00
43.00	04300	NURSERY	0	0	330,649	0	330,649	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	3,926,446	0	3,926,446	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	355,468	0	355,468	52.00
53.00	05300	ANESTHESIOLOGY	0	0	406,513	0	406,513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,640,711	0	4,640,711	54.00
60.00	06000	LABORATORY	0	0	4,083,144	0	4,083,144	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	506,883	506,883	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,001,565	0	1,001,565	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,164,122	0	3,164,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	316,346	0	316,346	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	142,555	0	142,555	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	406,816	0	406,816	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	254,378	0	254,378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	202,744	0	202,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,611,462	0	2,611,462	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	524,062	0	524,062	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	51,634	51,634	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	686,623	0	686,623	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	4,954,867	72,507	5,027,374	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)	389,057	0	36,678,630	0	36,678,630	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	79,708	0	79,708	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	23,398	0	23,398	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)	389,057	0	36,781,736	0	36,781,736	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,815	0	2,815	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,568	159,436	280,208	487,212	5.00
7.00	00700	OPERATION OF PLANT	7,500	888,891	46,712	943,103	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,786	0	13,786	8.00
9.00	00900	HOUSEKEEPING	0	77,108	0	77,108	9.00
10.00	01000	DIETARY	0	66,377	25,632	92,009	10.00
11.00	01100	CAFETERIA	0	36,785	38,147	74,932	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,980	0	4,980	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,943	755	59,698	14.00
15.00	01500	PHARMACY	0	31,252	8,338	39,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,666	0	43,666	16.00
17.00	01700	SOCIAL SERVICE	0	2,502	0	2,502	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,669	439,934	45,681	507,284	30.00
43.00	04300	NURSERY	0	8,950	3,839	12,789	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	650	249,367	432,772	682,789	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,855	4,031	19,886	52.00
53.00	05300	ANESTHESIOLOGY	0	7,314	15,058	22,372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130	180,583	290,745	471,458	54.00
60.00	06000	LABORATORY	65	108,480	73,248	181,793	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	196	21,749	11,415	33,360	65.00
66.00	06600	PHYSICAL THERAPY	188	115,649	18,175	134,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,376	0	6,376	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,598	0	2,598	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,306	44,080	48,386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	40,442	0	40,442	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	94,189	8,476	102,665	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	144,279	41,469	185,748	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)	77,966	2,826,612	1,388,781	4,293,359	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,254	0	22,254	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,966	2,848,866	1,388,781	4,315,613	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2018
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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	487,620					5.00
7.00	00700	OPERATION OF PLANT	42,180	985,401				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,031	7,556	25,380			8.00
9.00	00900	HOUSEKEEPING	11,127	42,266	0	130,569		9.00
10.00	01000	DIETARY	10,051	36,384	76	5,078	143,642	10.00
11.00	01100	CAFETERIA	11,152	20,164	113	2,814	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,389	2,730	0	381	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,668	32,309	24	4,509	0	14.00
15.00	01500	PHARMACY	12,327	17,130	0	2,391	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,484	23,935	0	3,340	0	16.00
17.00	01700	SOCIAL SERVICE	4,748	1,371	0	191	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	73,731	241,144	7,584	33,655	141,316	30.00
43.00	04300	NURSERY	3,548	4,906	196	685	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	38,961	136,687	2,800	19,076	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,830	8,690	206	1,213	0	52.00
53.00	05300	ANESTHESIOLOGY	4,488	4,009	0	559	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,866	98,985	3,431	13,814	0	54.00
60.00	06000	LABORATORY	44,302	59,462	14	8,298	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,763	11,921	0	1,664	0	65.00
66.00	06600	PHYSICAL THERAPY	36,069	63,392	3,532	8,847	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,842	3,495	0	488	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,715	1,424	0	199	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,562	2,361	641	329	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,592	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,066	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,919	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,475	22,168	0	3,094	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	5,973	51,629	0	7,205	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	47,395	79,085	6,099	11,037	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)	487,254	973,203	24,716	128,867	141,316	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	366	12,198	0	1,702	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	664	0	2,326	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)	487,620	985,401	25,380	130,569	143,642	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2018
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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	109,241					11.00
13.00	01300	NURSING ADMINISTRATION	1,683	16,208				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,377	0	106,623			14.00
15.00	01500	PHARMACY	3,291	0	409	75,227		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,454	0	11	0	93,993	16.00
17.00	01700	SOCIAL SERVICE	1,368	427	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	23,019	7,725	8,324	0	14,168	30.00
43.00	04300	NURSERY	935	314	111	0	1,487	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,041	2,301	14,049	0	9,775	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	983	329	117	0	518	52.00
53.00	05300	ANESTHESIOLOGY	2,260	759	1,246	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,198	0	6,299	0	8,311	54.00
60.00	06000	LABORATORY	10,302	0	44,631	0	8,401	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,210	0	1,132	0	1,442	65.00
66.00	06600	PHYSICAL THERAPY	11,584	0	1,837	0	1,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,074	0	89	0	135	67.00
68.00	06800	SPEECH PATHOLOGY	647	0	0	0	113	68.00
69.00	06900	ELECTROCARDIOLOGY	1,314	0	344	0	2,185	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,368	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,466	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	75,227	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,122	0	19	0	473	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,411	0	157	0	180	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	12,968	4,353	11,014	0	45,611	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)	109,241	16,208	106,623	75,227	93,993	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	0	0	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)	109,241	16,208	106,623	75,227	93,993	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 1:26 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	10,644					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,644		1,069,010	0	1,069,010	30.00
43.00	04300	NURSERY	0		24,993	0	24,993	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		914,635	0	914,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		35,795	0	35,795	52.00
53.00	05300	ANESTHESIOLOGY	0		35,693	0	35,693	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		666,625	0	666,625	54.00
60.00	06000	LABORATORY	0		357,373	0	357,373	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		65,574	0	65,574	65.00
66.00	06600	PHYSICAL THERAPY	0		260,725	0	260,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		15,528	0	15,528	67.00
68.00	06800	SPEECH PATHOLOGY	0		6,709	0	6,709	68.00
69.00	06900	ELECTROCARDIOLOGY	0		60,152	0	60,152	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		11,960	0	11,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		9,532	0	9,532	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		96,146	0	96,146	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		72,822	0	72,822	76.00
76.01	03950	DIABETIC EDUCATION	0		0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0		169,251	0	169,251	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0		403,580	0	403,580	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)	10,644	0	4,276,103	0	4,276,103	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		36,520	0	36,520	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		2,990	0	2,990	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)	10,644	0	4,315,613	0	4,315,613	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,376,817				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	15,915,308			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,627	277,794	2,305,691	-7,124,192	29,657,544	5.00
7.00	00700	OPERATION OF PLANT	36,947	46,310	666,107	0	2,565,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	37,106	0	245,180	8.00
9.00	00900	HOUSEKEEPING	3,205	0	381,718	0	676,738	9.00
10.00	01000	DIETARY	2,759	25,411	251,169	0	611,297	10.00
11.00	01100	CAFETERIA	1,529	37,818	373,809	0	678,280	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	254,177	0	388,586	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,450	748	216,828	0	405,569	14.00
15.00	01500	PHARMACY	1,299	8,266	505,380	0	749,722	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	581,508	0	941,758	16.00
17.00	01700	SOCIAL SERVICE	104	0	206,491	0	288,801	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,286	45,287	2,360,627	0	4,484,704	30.00
43.00	04300	NURSERY	372	3,806	123,818	0	215,759	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,365	429,046	878,593	0	2,369,630	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	659	3,996	129,983	0	232,962	52.00
53.00	05300	ANESTHESIOLOGY	304	14,928	0	0	272,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	288,240	1,487,027	0	3,154,485	54.00
60.00	06000	LABORATORY	4,509	72,617	960,175	0	2,694,446	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	11,317	465,957	0	715,421	65.00
66.00	06600	PHYSICAL THERAPY	4,807	18,018	1,459,979	0	2,193,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	265	0	161,682	0	233,677	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	72,989	0	104,317	68.00
69.00	06900	ELECTROCARDIOLOGY	179	43,700	166,991	0	277,447	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	157,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	125,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,272,288	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,681	0	164,659	0	333,000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	3,915	8,403	175,245	0	363,279	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,997	41,112	1,527,599	0	2,882,587	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)	117,489	1,376,817	15,915,308	-7,124,192	29,635,290	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	22,254	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	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)	2,848,866	1,388,781	6,151,205		7,124,192	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.058523	1.008690	0.386496		0.240215	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,815		487,620	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000177		0.016442	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: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	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	74,723				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	212,024			8.00
9.00	00900	HOUSEKEEPING	3,205	0	70,945		9.00
10.00	01000	DIETARY	2,759	637	2,759	19,702	10.00
11.00	01100	CAFETERIA	1,529	948	1,529	0	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,450	199	2,450	0	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	16.00
17.00	01700	SOCIAL SERVICE	104	0	104	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,286	63,353	18,286	19,383	30.00
43.00	04300	NURSERY	372	1,638	372	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,365	23,388	10,365	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	659	1,719	659	0	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	28,661	7,506	0	54.00
60.00	06000	LABORATORY	4,509	117	4,509	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	65.00
66.00	06600	PHYSICAL THERAPY	4,807	29,509	4,807	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	265	0	265	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	68.00
69.00	06900	ELECTROCARDIOLOGY	179	5,355	179	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,681	0	1,681	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,997	50,955	5,997	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)	73,798	206,479	70,020	19,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,545	0	319	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)	3,181,656	328,474	975,768	914,550	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.579340	1.549230	13.753866	46.419145	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	985,401	25,380	130,569	143,642	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.187385	0.119703	1.840426	7.290732	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: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG 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	182,470					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,794,302				14.00
15.00	01500	PHARMACY	0	6,890	1,272,288			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	190	0	4,173		16.00
17.00	01700	SOCIAL SERVICE	4,812	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	86,962	140,077	0	629	100	30.00
43.00	04300	NURSERY	3,530	1,868	0	66	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,904	236,430	0	434	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,706	1,961	0	23	0	52.00
53.00	05300	ANESTHESIOLOGY	8,546	20,962	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,001	0	369	0	54.00
60.00	06000	LABORATORY	0	751,078	0	373	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	19,044	0	64	0	65.00
66.00	06600	PHYSICAL THERAPY	0	30,914	0	53	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,495	0	6	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,797	0	97	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	157,643	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	125,644	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,272,288	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	326	0	21	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	2,636	0	8	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	49,010	185,346	0	2,025	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)	182,470	1,794,302	1,272,288	4,173	100	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	0	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)	507,901	670,029	1,033,551	1,333,673	389,057	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.783477	0.373420	0.812356	319.595734	3,890.570000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,208	106,623	75,227	93,993	10,644	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.088826	0.059423	0.059127	22.524083	106.440000	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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet B-1
Date/Time Prepared:
2/26/2020 1:26 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	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.01	03950	DIABETIC EDUCATION	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-2

Date/Time Prepared:
2/26/2020 1:26 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY & ANCILLARY		1	30.00	-579,390
8.00		IV THERAPY		1	64.00	506,883
9.00		ANCILLARY		1	91.00	72,507
10.00		DIABETIC EDUCATION		1	30.00	-51,634
11.00		DIABETIC EDUCATION		1	76.01	51,634

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 1:26 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,039,135		8,039,135	0	0	30.00	
43.00	04300	NURSERY	330,649		330,649	0	0	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,926,446		3,926,446	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	355,468		355,468	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	406,513		406,513	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,640,711		4,640,711	0	0	54.00	
60.00	06000	LABORATORY	4,083,144		4,083,144	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	506,883		506,883	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1,001,565	0	1,001,565	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	3,164,122	0	3,164,122	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	316,346	0	316,346	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	142,555	0	142,555	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	406,816		406,816	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	254,378		254,378	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,744		202,744	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,611,462		2,611,462	0	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	524,062		524,062	0	0	76.00	
76.01	03950	DIABETIC EDUCATION	51,634		51,634	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	686,623		686,623	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,027,374		5,027,374	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	614,435		614,435		0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	37,293,065	0	37,293,065	0	0	200.00	
201.00		Less Observation Beds	614,435		614,435		0	201.00	
202.00		Total (see instructions)	36,678,630	0	36,678,630	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 1:26 pm

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,525,294		5,525,294			30.00
43.00	04300	NURSERY	311,362		311,362			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	755,806	6,499,636	7,255,442	0.541173	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,251,842	518,832	1,770,674	0.200753	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	321,714	1,032,365	1,354,079	0.300214	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	851,417	39,735,423	40,586,840	0.114340	0.000000	54.00
60.00	06000	LABORATORY	2,939,010	15,540,128	18,479,138	0.220960	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,403,550	405,952	1,809,502	0.280123	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	985,693	2,110,863	3,096,556	0.323445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	722,436	5,600,303	6,322,739	0.500435	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	443,584	385,048	828,632	0.381769	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	53,375	503,611	556,986	0.255940	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	311,055	3,423,589	3,734,644	0.108930	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,094,556	1,086,222	2,180,778	0.116646	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	413,738	375,296	789,034	0.256952	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,264,746	6,902,550	9,167,296	0.284867	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	110,782	110,782	4.730570	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	62	133,431	133,493	0.386792	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	2,863	1,336,470	1,339,333	0.512660	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,069,358	19,474,106	20,543,464	0.244719	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,260	957,907	999,167	0.614947	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,762,721	106,132,514	126,895,235			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,762,721	106,132,514	126,895,235			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	914,635	7,255,442	0.126062	77,933	9,824
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,795	1,770,674	0.020215	1,554	31
53.00	05300	ANESTHESIOLOGY	35,693	1,354,079	0.026360	34,780	917
54.00	05400	RADIOLOGY-DIAGNOSTIC	666,625	40,586,840	0.016425	313,667	5,152
60.00	06000	LABORATORY	357,373	18,479,138	0.019339	987,694	19,101
64.00	06400	INTRAVENOUS THERAPY	0	1,809,502	0.000000	479,810	0
65.00	06500	RESPIRATORY THERAPY	65,574	3,096,556	0.021176	481,288	10,192
66.00	06600	PHYSICAL THERAPY	260,725	6,322,739	0.041236	152,390	6,284
67.00	06700	OCCUPATIONAL THERAPY	15,528	828,632	0.018739	81,577	1,529
68.00	06800	SPEECH PATHOLOGY	6,709	556,986	0.012045	31,842	384
69.00	06900	ELECTROCARDIOLOGY	60,152	3,734,644	0.016106	160,025	2,577
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,960	2,180,778	0.005484	417,507	2,290
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,532	789,034	0.012081	121,855	1,472
73.00	07300	DRUGS CHARGED TO PATIENTS	96,146	9,167,296	0.010488	663,861	6,963
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,822	110,782	0.657345	0	0
76.01	03950	DIABETIC EDUCATION	0	133,493	0.000000	62	0
76.97	07697	CARDIAC REHABILITATION	169,251	1,339,333	0.126370	1,397	177
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	403,580	20,543,464	0.019645	185,580	3,646
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,705	999,167	0.081773	0	0
200.00		Total (lines 50 through 199)	3,263,805	121,058,579		4,192,822	70,539

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1322		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 1:26 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	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: 14-1322		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 1:26 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	7,255,442	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,770,674	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	1,354,079	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	40,586,840	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	18,479,138	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,809,502	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	3,096,556	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,322,739	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	828,632	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	556,986	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	3,734,644	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	2,180,778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	789,034	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	9,167,296	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	110,782	0.000000	76.00
76.01	03950	DIABETIC EDUCATION		0	0	0	133,493	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,339,333	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	20,543,464	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	999,167	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	121,058,579		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1322		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 1:26 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	77,933	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	1,554	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	34,780	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	313,667	0	0	0	54.00
60.00	06000	LABORATORY		0.000000	987,694	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	479,810	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	481,288	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	152,390	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	81,577	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	31,842	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	160,025	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	417,507	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	121,855	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	663,861	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	62	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	1,397	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000000	185,580	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)			4,192,822	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 1:26 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.541173	0	1,833,240	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200753	0	668	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.300214	0	190,149	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114340	0	13,787,478	0	0	54.00	
60.00	06000	LABORATORY	0.220960	0	5,033,019	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.280123	0	131,364	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.323445	0	662,434	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.500435	0	1,769,119	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.381769	0	59,462	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.255940	0	29,777	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.108930	0	1,395,493	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116646	0	223,144	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256952	0	96,091	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284867	0	3,195,695	8,965	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.730570	0	58,138	0	0	76.00	
76.01	03950	DIABETIC EDUCATION	0.386792	0	27,798	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0.512660	0	726,803	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.244719	0	5,471,294	1,335	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614947	0	464,154	0	0	92.00	
200.00		Subtotal (see instructions)		0	35,155,320	10,300	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	35,155,320	10,300	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 1:26 pm

				Title XVIII	Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	992,100	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134	0		52.00
53.00	05300	ANESTHESIOLOGY	57,085	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,576,460	0		54.00
60.00	06000	LABORATORY	1,112,096	0		60.00
64.00	06400	INTRAVENOUS THERAPY	36,798	0		64.00
65.00	06500	RESPIRATORY THERAPY	214,261	0		65.00
66.00	06600	PHYSICAL THERAPY	885,329	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,701	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,621	0		68.00
69.00	06900	ELECTROCARDIOLOGY	152,011	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,029	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,691	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	910,348	2,554		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	275,026	0		76.00
76.01	03950	DIABETIC EDUCATION	10,752	0		76.01
76.97	07697	CARDIAC REHABILITATION	372,603	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,338,930	327		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	285,430	0		92.00
200.00		Subtotal (see instructions)	8,300,405	2,881		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,300,405	2,881		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:

Worksheet D

Component CCN: 14-Z322

From 10/01/2018

Part V

To 09/30/2019

Date/Time Prepared:

2/26/2020 1:26 pm

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.541173	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200753	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300214	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114340	0	0	0	54.00
60.00	06000	LABORATORY	0.220960	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.280123	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.323445	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.500435	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381769	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.255940	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108930	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116646	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256952	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284867	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.730570	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.386792	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.512660	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.244719	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614947	0	0	0	92.00
200.00		Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322

Period:

Worksheet D

Component CCN: 14-Z322

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/26/2020 1:26 pm

				Title XVIII	Swing Beds - SNF	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	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: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 1:26 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)	4,746	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,856	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)	2,500	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	580	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)	1,213	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	78	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,286	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)	427	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)	917	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)	8,039,135	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,987	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)	12,261	25.00	
26.00	Total swing-bed cost (see instructions)	3,109,858	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,929,277	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00	
29.00	Private room charges (excluding swing-bed charges)	0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,929,277	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)	1,725.94	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,219,559	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)	2,219,559	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/26/2020 1:26 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)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,045,376
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,264,935
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					736,976
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,582,687
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,319,663
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					356
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,725.94
89.00	Observation bed cost (line 87 x line 88) (see instructions)					614,435

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/26/2020 1:26 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	1,069,010	8,039,135	0.132976	614,435	81,705	90.00
91.00	Nursing School cost	0	8,039,135	0.000000	614,435	0	91.00
92.00	Allied health cost	0	8,039,135	0.000000	614,435	0	92.00
93.00	All other Medical Education	0	8,039,135	0.000000	614,435	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 1:26 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		2,057,637		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.541173	77,933	42,175	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200753	1,554	312	52.00
53.00	05300	ANESTHESIOLOGY	0.300214	34,780	10,441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114340	313,667	35,865	54.00
60.00	06000	LABORATORY	0.220960	987,694	218,241	60.00
64.00	06400	INTRAVENOUS THERAPY	0.280123	479,810	134,406	64.00
65.00	06500	RESPIRATORY THERAPY	0.323445	481,288	155,670	65.00
66.00	06600	PHYSICAL THERAPY	0.500435	152,390	76,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381769	81,577	31,144	67.00
68.00	06800	SPEECH PATHOLOGY	0.255940	31,842	8,150	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108930	160,025	17,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116646	417,507	48,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256952	121,855	31,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284867	663,861	189,112	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.730570	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.386792	62	24	76.01
76.97	07697	CARDIAC REHABILITATION	0.512660	1,397	716	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.244719	185,580	45,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614947	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,192,822	1,045,376	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		4,192,822		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1322 Component CCN: 14-Z322	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 1:26 pm	
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.541173	8,001	4,330	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200753	198	40	52.00
53.00	05300	ANESTHESIOLOGY	0.300214	2,600	781	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114340	131,116	14,992	54.00
60.00	06000	LABORATORY	0.220960	448,523	99,106	60.00
64.00	06400	INTRAVENOUS THERAPY	0.280123	341,551	95,676	64.00
65.00	06500	RESPIRATORY THERAPY	0.323445	161,785	52,329	65.00
66.00	06600	PHYSICAL THERAPY	0.500435	319,556	159,917	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381769	213,065	81,342	67.00
68.00	06800	SPEECH PATHOLOGY	0.255940	9,328	2,387	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108930	17,124	1,865	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116646	202,304	23,598	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256952	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284867	396,180	112,859	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.730570	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.386792	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.512660	213	109	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.244719	166,565	40,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614947	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,418,109	690,093	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)		2,418,109		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/26/2020 1:26 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,303,286	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)		8,303,286	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)		8,386,319	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)		43,401	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,983,745	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,359,173	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,359,173	30.00
31.00	Primary payer payments		153	31.00
32.00	Subtotal (line 30 minus line 31)		2,359,020	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)		1,016,964	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		661,027	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		920,505	36.00
37.00	Subtotal (see instructions)		3,020,047	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)		3,020,047	40.00
40.01	Sequestration adjustment (see instructions)		60,401	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,500,193	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-540,547	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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/26/2020 1:26 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		3,508,156		3,662,425	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	04/11/2019	35,143	04/11/2019	5,774	3.50
3.51		09/10/2019	12,255	09/10/2019	156,458	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)		-47,398		-162,232	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)		3,460,758		3,500,193	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		511,126		540,547	6.02
7.00	Total Medicare program liability (see instructions)		2,949,632		2,959,646	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: 14-1322

Period:

Worksheet E-1

Component CCN: 14-Z322

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/26/2020 1:26 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		3,579,887		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	04/11/2019	87,073		0	3.50
3.51		09/10/2019	36,056		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)		-123,129		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)		3,456,758		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		547,494		0	6.02
7.00	Total Medicare program liability (see instructions)		2,909,264		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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/26/2020 1:26 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: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet E-2
		Component CCN: 14-Z322		Date/Time Prepared: 2/26/2020 1:26 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)	2,342,860	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)	696,994	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	1,344	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)	3,039,854	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,039,854	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)	3,039,854	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	71,217	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)	2,968,637	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)	2,968,637	0	19.00
19.01	Sequestration adjustment (see instructions)	59,373	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	3,456,758	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)	-547,494	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: 14-1322	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/26/2020 1:26 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,264,935	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)		3,264,935	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,297,584	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)		3,297,584	19.00
20.00	Deductibles (exclude professional component)		347,792	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,949,792	22.00
23.00	Coinsurance		4,433	23.00
24.00	Subtotal (line 22 minus line 23)		2,945,359	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		99,184	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		64,470	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		93,824	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,009,829	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)		3,009,829	30.00
30.01	Sequestration adjustment (see instructions)		60,197	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		3,460,758	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)		-511,126	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: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/26/2020 1:26 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	21,173,101	0	0	0	1.00
2.00 Temporary investments	7,062,825	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	7,166,037	0	0	0	4.00
5.00 Other receivable	320,122	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-2,424,600	0	0	0	6.00
7.00 Inventory	631,981	0	0	0	7.00
8.00 Prepaid expenses	226,070	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	61,330	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	34,216,866	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,454,817	0	0	0	12.00
13.00 Land improvements	6,078,200	0	0	0	13.00
14.00 Accumulated depreciation	-4,116,980	0	0	0	14.00
15.00 Buildings	42,874,213	0	0	0	15.00
16.00 Accumulated depreciation	-22,292,403	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	17,545,184	0	0	0	23.00
24.00 Accumulated depreciation	-13,233,620	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	1,966,594	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	30,276,005	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	46,251,337	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	28,113,478	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	74,364,815	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	138,857,686	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,616,666	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,953,389	0	0	0	38.00
39.00 Payroll taxes payable	14,500	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	-100,578	0	0	0	43.00
44.00 Other current liabilities	640,368	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,124,345	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	442,630	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	442,630	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	4,566,975	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	134,290,711				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)	134,290,711	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	138,857,686	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/26/2020 1:26 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		121,325,368		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,965,343				2.00
3.00	Total (sum of line 1 and line 2)		134,290,711		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)		134,290,711		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)		134,290,711		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: 14-1322

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2020 1:26 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,564,172		3,564,172	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,468,479		1,468,479	5.00
6.00	Swing bed - NF	547,080		547,080	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)	5,579,731		5,579,731	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)	5,579,731		5,579,731	17.00
18.00	Ancillary services	14,004,269	87,605,184	101,609,453	18.00
19.00	Outpatient services	1,131,819	20,661,845	21,793,664	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	NURSERY	324,765	0	324,765	27.00
27.01	PROFESSIONAL FEES	609,265	11,497,801	12,107,066	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,649,849	119,764,830	141,414,679	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,721,079		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)		44,721,079		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1322

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/26/2020 1:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	141,414,679	1.00
2.00	Less contractual allowances and discounts on patients' accounts	85,298,043	2.00
3.00	Net patient revenues (line 1 minus line 2)	56,116,636	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,721,079	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,395,557	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	51,600	6.00
7.00	Income from investments	1,183,644	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	169,497	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	158	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	6,950	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN INTEREST OF NET ASSETS	480,156	24.00
24.01	MISCELLANEOUS INCOME	43,291	24.01
24.02	DEFERRED TAX BENEFIT	53,794	24.02
24.03	REALIZED GAINS ON INVESTMENTS FD	374,610	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
25.00	Total other income (sum of lines 6-24)	2,363,700	25.00
26.00	Total (line 5 plus line 25)	13,759,257	26.00
27.00	LOSS ON DISPOSAL OF FIXED ASSETS	19,376	27.00
27.01	DEFERRED COMP EXP	17,760	27.01
27.02	LOSS ON BOND REFUNDING	67,033	27.02
27.03	UNREALIZED GAIN/LOSS ON INVESTMENTS	689,745	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	793,914	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,965,343	29.00