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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1322	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/25/2019 9:39 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2019 Time: 9:39 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (14-1322) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ANDY COSTIC
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-116,324	-290,321	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	-117,804	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-234,128	-290,321	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 9:39 am

	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	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 9:39 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 9:39 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 9:39 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 9:39 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	23,127	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 9:39 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	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)	04/01/2017	06/30/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2019 9:39 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/01/2019	Y	02/01/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2019 9:39 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	PRORATIONS		Y	Y	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/25/2019 9:39 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2019 9:39 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	73,576.00	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	73,576.00	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	73,576.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2019 9:39 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,396	237	2,596			1.00
2.00	HMO and other (see instructions)	119	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	809	0	1,248			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	72			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,205	237	3,916			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		157	356			13.00
14.00	Total (see instructions)	2,205	394	4,272	0.00	272.75	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	272.75	27.00
28.00	Observation Bed Days		15	186			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			40			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	70			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 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2019 9:39 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	417	110	890	1.00
2.00	HMO and other (see instructions)			29	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	417	110	890	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 10/01/2017 To 09/30/2018 | Worksheet S-10 | Date/Time Prepared: 2/25/2019 9:39 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.319447	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,540,308	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	3,017,236	5.00
6.00	Medicaid charges	21,191,782	6.00
7.00	Medicaid cost (line 1 times line 6)	6,769,651	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)	1,212,107	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	20,564	9.00
10.00	Stand-alone CHIP charges	163,349	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	52,181	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	31,617	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)	1,243,724	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)	794,635	151,209	945,844	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	253,844	151,209	405,053	21.00
22.00	Payments received from patients for amounts previously written off as charity care	10,856	0	10,856	22.00
23.00	Cost of charity care (line 21 minus line 22)	242,988	151,209	394,197	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)	2,064,357	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	497,526	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	765,424	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,298,933	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	682,838	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,077,035	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,320,759	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,042,545	3,042,545	2,377,703	5,420,248	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,323,928	1,323,928	96,771	1,420,699	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	553,526	5,122,589	5,676,115	-78,291	5,597,824	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,272,871	4,717,558	6,990,429	-92,256	6,898,173	5.00
7.00	00700	OPERATION OF PLANT	528,967	715,721	1,244,688	0	1,244,688	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	203,717	203,717	8.00
9.00	00900	HOUSEKEEPING	462,412	230,012	692,424	-203,717	488,707	9.00
10.00	01000	DIETARY	600,349	409,044	1,009,393	-638,414	370,979	10.00
11.00	01100	CAFETERIA	0	0	0	636,706	636,706	11.00
13.00	01300	NURSING ADMINISTRATION	451,475	58,386	509,861	-176,666	333,195	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	275,428	316,301	591,729	-277,852	313,877	14.00
15.00	01500	PHARMACY	548,003	1,276,245	1,824,248	-1,238,489	585,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	535,816	96,024	631,840	0	631,840	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	169,186	169,186	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	893,459	0	893,459	78,291	971,750	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,565,288	1,662,215	3,227,503	711,432	3,938,935	30.00
43.00	04300	NURSERY	0	0	0	133,139	133,139	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	898,877	677,479	1,576,356	1,999	1,578,355	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	764,064	242,274	1,006,338	-844,571	161,767	52.00
53.00	05300	ANESTHESIOLOGY	0	251,897	251,897	0	251,897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,413,051	711,557	2,124,608	-49,776	2,074,832	54.00
60.00	06000	LABORATORY	913,706	1,242,240	2,155,946	5,019	2,160,965	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	455,204	38,029	493,233	0	493,233	65.00
66.00	06600	PHYSICAL THERAPY	1,536,041	86,272	1,622,313	0	1,622,313	66.00
68.00	06800	SPEECH PATHOLOGY	72,151	1,068	73,219	0	73,219	68.00
69.00	06900	ELECTROCARDIOLOGY	150,403	25,363	175,766	0	175,766	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	147,843	147,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	128,187	128,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,299,584	1,299,584	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	158,508	14,780	173,288	0	173,288	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,405,923	3,190,211	4,596,134	-7,327	4,588,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,382,218	2,382,218	-2,382,218	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,455,522	27,833,956	44,289,478	0	44,289,478	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		TOTAL (SUM OF LINES 118 through 199)	16,455,522	27,833,956	44,289,478	0	44,289,478	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-608,288	4,811,960		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-38,412	1,382,287		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,303	5,588,521		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,000,250	5,897,923		5.00
7.00	00700	OPERATION OF PLANT	0	1,244,688		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	203,717		8.00
9.00	00900	HOUSEKEEPING	0	488,707		9.00
10.00	01000	DIETARY	0	370,979		10.00
11.00	01100	CAFETERIA	-167,706	469,000		11.00
13.00	01300	NURSING ADMINISTRATION	0	333,195		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	313,877		14.00
15.00	01500	PHARMACY	0	585,759		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-664	631,176		16.00
17.00	01700	SOCIAL SERVICE	0	169,186		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-971,750	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,183,095	2,755,840		30.00
43.00	04300	NURSERY	0	133,139		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,578,355		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	161,767		52.00
53.00	05300	ANESTHESIOLOGY	0	251,897		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,074,832		54.00
60.00	06000	LABORATORY	-4,094	2,156,871		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	493,233		65.00
66.00	06600	PHYSICAL THERAPY	-88,929	1,533,384		66.00
68.00	06800	SPEECH PATHOLOGY	0	73,219		68.00
69.00	06900	ELECTROCARDIOLOGY	0	175,766		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	147,843		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,187		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,299,584		73.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	173,288		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,534,817	2,053,990		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,607,308	37,682,170		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)	-6,607,308	37,682,170		200.00

RECLASSIFICATIONS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 9:39 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - STERILE PROCESSING				
1.00	OPERATING ROOM	50.00	62,110	54,544	1.00
	0		62,110	54,544	
	B - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	540,156	171,276	1.00
2.00	NURSERY	43.00	101,086	32,053	2.00
	0		641,242	203,329	
	C - CASE MANAGEMENT				
1.00	SOCIAL SERVICE	17.00	169,186	0	1.00
	0		169,186	0	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	92,256	1.00
	0		0	92,256	
	E - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,299,584	1.00
2.00	LABORATORY	60.00	0	5,019	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	1,304,603	
	F - LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	34,575	169,142	1.00
	0		34,575	169,142	
	G - IMPLANTS & MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	147,843	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	128,187	2.00
3.00		0.00	0	0	3.00
	0		0	276,030	
	H - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	379,331	257,375	1.00
	0		379,331	257,375	
	I - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,178,771	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	69,377	2.00
	0		0	2,248,148	
	J - BOND AMORTIZATION EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,933	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,137	2.00
	0		0	134,070	
	K - CRNA BENEFITS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	78,291	1.00
	0		0	78,291	
500.00	Grand Total: Increases		1,286,444	4,817,788	500.00

RECLASSIFICATIONS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 9:39 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	62,110	54,544	0		1.00
	0		62,110	54,544			
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	641,242	203,329	0		1.00
2.00		0.00	0	0	0		2.00
	0		641,242	203,329			
	C - CASE MANAGEMENT						
1.00	NURSING ADMINISTRATION	13.00	169,186	0	0		1.00
	0		169,186	0			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,256	0		1.00
	0		0	92,256			
	E - DRUG EXPENSE						
1.00	DIETARY	10.00	0	1,708	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	7,480	0		2.00
3.00	PHARMACY	15.00	0	1,238,312	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,776	0		4.00
5.00	EMERGENCY	91.00	0	7,327	0		5.00
	0		0	1,304,603			
	F - LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	34,575	169,142	0		1.00
	0		34,575	169,142			
	G - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	161,198	0		1.00
2.00	PHARMACY	15.00	0	177	0		2.00
3.00	OPERATING ROOM	50.00	0	114,655	0		3.00
	0		0	276,030			
	H - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	379,331	257,375	0		1.00
	0		379,331	257,375			
	I - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,248,148	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	2,248,148			
	J - BOND AMORTIZATION EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	134,070	14		1.00
2.00		0.00	0	0	14		2.00
	0		0	134,070			
	K - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	78,291	0		1.00
	0		0	78,291			
500.00	Grand Total: Decreases		1,286,444	4,817,788			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2019 9:39 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,340,955	116,067	0	116,067	2,205	1.00
2.00	Land Improvements	6,048,558	22,839	0	22,839	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	42,471,731	136,012	0	136,012	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,331,965	1,072,001	0	1,072,001	939,325	6.00
7.00	HIT designated Assets	1,433,236	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,626,445	1,346,919	0	1,346,919	941,530	8.00
9.00	Reconciling Items	-101,884	-72,969	0	-72,969	0	9.00
10.00	Total (line 8 minus line 9)	66,728,329	1,419,888	0	1,419,888	941,530	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	6,071,397	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	42,607,743	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,464,641	0	6.00
7.00	HIT designated Assets	1,433,236	0	7.00
8.00	Subtotal (sum of lines 1-7)	67,031,834	0	8.00
9.00	Reconciling Items	-174,853	0	9.00
10.00	Total (line 8 minus line 9)	67,206,687	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2019 9:39 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,042,545	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,323,928	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,366,473	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	3,042,545		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,323,928		2.00
3.00	Total (sum of lines 1-2)	0	4,366,473		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2019 9:39 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	50,133,957	0	50,133,957	0.747913	68,999	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,897,877	0	16,897,877	0.252087	23,257	2.00
3.00	Total (sum of lines 1-2)	67,031,834	0	67,031,834	1.000000	92,256	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	68,999	3,062,867	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	23,257	1,305,532	0	2.00
3.00	Total (sum of lines 1-2)	0	0	92,256	4,368,399	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	1,550,161	68,999	0	129,933	4,811,960	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,361	23,257	0	4,137	1,382,287	2.00
3.00	Total (sum of lines 1-2)	1,599,522	92,256	0	134,070	6,194,247	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/25/2019 9:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-628,610	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-20,016	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-5,397	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	-3,445	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-10,389	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	-3,657,912			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-33,354	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	475,365			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-167,706	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	-664	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	-971,750	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	*** Cost Center Deleted ***	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	-156,919	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INCOME - A&G	B	-594	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/25/2019 9:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	PHYSICIAN LOAN FORGIVENESS	A	-35,276	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MISC INCOME - LAB	B	-4,094	LABORATORY	60.00	0	33.03
33.04	MISC INCOME - PT	B	-88,929	PHYSICAL THERAPY	66.00	0	33.04
34.00	PROVIDER TAX	A	-1,142,764	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MUTUAL FUND FEES	A	82,575	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADVERTISING EXPENSE	A	-60,000	ADULTS & PEDIATRICS	30.00	0	35.00
35.01	MARKETING - SALARIES	A	-43,804	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	MARKETING - BENEFITS	A	-9,303	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.02
35.03	MARKETING - OTHER	A	-89,869	ADMINISTRATIVE & GENERAL	5.00	0	35.03
36.00	FUNDED DEPRECIATION TRUSTEE FEES	A	19,738	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ALMH FOUNDATION MGMT/ACCT SVCS	B	-16,800	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	LOBBYING EXPENSE	A	-28,834	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	SALE OF AR AMORTIZATION	A	-2,689	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	RENTAL INCOME	B	-5,868	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,607,308				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 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2019 9:39 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO POOLED CAPITAL - BLDG	20,231	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO POOLED CAPITAL - MME	663	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO DIRECT CAPITAL - BLDG	91	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO DIRECT CAPITAL - MME	137,860	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	18,706	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,100,911	1,299,999	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	2,123,924	2,627,022	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	63,175	63,175	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,465,561	3,990,196	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL 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 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2019 9:39 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	20,231	9		1.00
2.00	663	9		2.00
3.00	91	9		3.00
4.00	137,860	9		4.00
4.01	18,706	0		4.01
4.02	800,912	0		4.02
4.03	-503,098	0		4.03
4.04	0	0		4.04
5.00	475,365			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 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2019 9:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	9,619	0	9,619	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	2,348	0	2,348	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,123,095	1,123,095	0	0	0	3.00
4.00	50.00	OPERATING ROOM	71,315	0	71,315	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	205,789	0	205,789	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	660	0	660	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	1,540	0	1,540	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	4,663	0	4,663	0	0	8.00
9.00	91.00	EMERGENCY	61,668	0	61,668	0	0	9.00
10.00	91.00	EMERGENCY	2,693,649	2,534,817	158,832	0	0	10.00
200.00			4,174,346	3,657,912	516,434		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,123,095		3.00
4.00	50.00	OPERATING ROOM	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	91.00	EMERGENCY	0	0	0	2,534,817		10.00
200.00			0	0	0	3,657,912		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,811,960	4,811,960				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,382,287		1,382,287			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,588,521	4,754	0	5,593,275		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,897,923	339,723	285,408	833,142	7,356,196	5.00
7.00	00700	OPERATION OF PLANT	1,244,688	1,507,053	39,941	197,709	2,989,391	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	203,717	23,285	0	12,923	239,925	8.00
9.00	00900	HOUSEKEEPING	488,707	130,241	0	159,910	778,858	9.00
10.00	01000	DIETARY	370,979	174,250	23,376	82,609	651,214	10.00
11.00	01100	CAFETERIA	469,000	0	40,121	141,780	650,901	11.00
13.00	01300	NURSING ADMINISTRATION	333,195	8,412	0	105,509	447,116	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	313,877	96,025	946	79,731	490,579	14.00
15.00	01500	PHARMACY	585,759	52,787	4,819	204,824	848,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	631,176	73,756	0	200,269	905,201	16.00
17.00	01700	SOCIAL SERVICE	169,186	0	0	63,236	232,422	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,755,840	742,596	46,906	786,939	4,332,281	30.00
43.00	04300	NURSERY	133,139	15,117	3,578	37,782	189,616	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,578,355	421,200	353,571	359,182	2,712,308	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	161,767	27,267	4,347	45,906	239,287	52.00
53.00	05300	ANESTHESIOLOGY	251,897	12,354	17,427	0	281,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,074,832	305,019	391,778	528,148	3,299,777	54.00
60.00	06000	LABORATORY	2,156,871	183,231	71,718	341,510	2,753,330	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	493,233	36,736	9,727	170,139	709,835	65.00
66.00	06600	PHYSICAL THERAPY	1,533,384	206,110	20,443	574,117	2,334,054	66.00
68.00	06800	SPEECH PATHOLOGY	73,219	4,389	0	26,967	104,575	68.00
69.00	06900	ELECTROCARDIOLOGY	175,766	7,274	26,899	56,215	266,154	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,843	0	0	0	147,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	128,187	0	0	0	128,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,299,584	0	0	0	1,299,584	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	173,288	159,093	0	59,245	391,626	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,053,990	243,699	41,282	525,483	2,864,454	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)	37,682,170	4,774,371	1,382,287	5,593,275	37,644,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,589	0	0	37,589	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)	37,682,170	4,811,960	1,382,287	5,593,275	37,682,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,356,196					5.00
7.00	00700	OPERATION OF PLANT	725,140	3,714,531				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,199	29,216	327,340			8.00
9.00	00900	HOUSEKEEPING	188,928	163,417	0	1,131,203		9.00
10.00	01000	DIETARY	157,966	218,637	595	70,224	1,098,636	10.00
11.00	01100	CAFETERIA	157,890	0	1,022	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	108,457	10,555	0	3,390	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	119,000	120,485	330	38,699	0	14.00
15.00	01500	PHARMACY	205,746	66,233	0	21,274	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,576	92,543	0	29,724	0	16.00
17.00	01700	SOCIAL SERVICE	56,379	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,050,882	931,757	98,063	299,270	1,037,886	30.00
43.00	04300	NURSERY	45,995	18,968	3,266	6,092	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	657,927	528,491	34,771	169,747	35,995	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,044	34,213	3,968	10,989	0	52.00
53.00	05300	ANESTHESIOLOGY	68,327	15,500	0	4,979	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,430	382,716	42,923	122,925	0	54.00
60.00	06000	LABORATORY	667,878	229,905	25	73,844	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	172,185	46,093	0	14,805	0	65.00
66.00	06600	PHYSICAL THERAPY	566,174	258,611	44,564	83,064	0	66.00
68.00	06800	SPEECH PATHOLOGY	25,367	5,507	0	1,769	0	68.00
69.00	06900	ELECTROCARDIOLOGY	64,561	9,127	6,803	2,931	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,862	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,094	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	315,241	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	94,997	199,618	0	64,116	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	694,833	305,775	82,611	98,212	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)	7,347,078	3,667,367	318,941	1,116,054	1,073,881	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,118	47,164	0	15,149	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,399	0	24,755	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)	7,356,196	3,714,531	327,340	1,131,203	1,098,636	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 9:39 am

		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	809,813					11.00
13.00	01300	NURSING ADMINISTRATION	15,847	585,365				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,892	0	792,985			14.00
15.00	01500	PHARMACY	27,346	0	2,598	1,171,386		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,155	0	31	0	1,303,230	16.00
17.00	01700	SOCIAL SERVICE	9,467	14,499	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	162,654	268,443	58,389	0	211,812	30.00
43.00	04300	NURSERY	5,973	8,026	916	0	21,348	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,663	97,795	106,330	0	157,775	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,273	9,752	1,113	0	9,006	52.00
53.00	05300	ANESTHESIOLOGY	14,872	25,654	10,177	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,618	0	46,802	0	27,686	54.00
60.00	06000	LABORATORY	85,573	0	356,669	0	68,714	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	32,750	0	5,409	0	27,019	65.00
66.00	06600	PHYSICAL THERAPY	92,521	0	12,229	0	23,683	66.00
68.00	06800	SPEECH PATHOLOGY	3,413	0	0	0	2,335	68.00
69.00	06900	ELECTROCARDIOLOGY	9,467	0	2,004	0	38,693	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	62,727	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	54,388	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,171,386	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,955	0	918	0	5,337	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	93,374	161,196	72,285	0	700,149	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)	809,813	585,365	792,985	1,171,386	1,293,557	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	9,673	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)	809,813	585,365	792,985	1,171,386	1,303,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 9:39 am

		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	312,767					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	312,767	0	8,764,204	-474,787	8,289,417	30.00
43.00	04300	NURSERY	0	0	300,200	0	300,200	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,566,802	0	4,566,802	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	373,645	0	373,645	52.00
53.00	05300	ANESTHESIOLOGY	0	0	421,187	0	421,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,816,877	0	4,816,877	54.00
60.00	06000	LABORATORY	0	0	4,235,938	0	4,235,938	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	366,088	366,088	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,008,096	0	1,008,096	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,414,900	0	3,414,900	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	142,966	0	142,966	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	399,740	0	399,740	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	246,432	0	246,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	213,669	0	213,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,786,211	0	2,786,211	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	40,099	40,099	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	766,567	0	766,567	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	5,072,889	68,600	5,141,489	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)	312,767	0	37,530,323	0	37,530,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	109,020	0	109,020	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	42,827	0	42,827	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)	312,767	0	37,682,170	0	37,682,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,754	0	4,754	4,754	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,124	339,723	285,408	638,255	704	5.00
7.00	00700	OPERATION OF PLANT	10,976	1,507,053	39,941	1,557,970	168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,285	0	23,285	11	8.00
9.00	00900	HOUSEKEEPING	0	130,241	0	130,241	136	9.00
10.00	01000	DIETARY	0	174,250	23,376	197,626	70	10.00
11.00	01100	CAFETERIA	0	0	40,121	40,121	121	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,412	0	8,412	90	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	96,025	946	96,971	68	14.00
15.00	01500	PHARMACY	0	52,787	4,819	57,606	174	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	73,756	0	73,756	170	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	54	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,572	742,596	46,906	802,074	670	30.00
43.00	04300	NURSERY	0	15,117	3,578	18,695	32	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,905	421,200	353,571	796,676	306	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,267	4,347	31,614	39	52.00
53.00	05300	ANESTHESIOLOGY	0	12,354	17,427	29,781	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130	305,019	391,778	696,927	449	54.00
60.00	06000	LABORATORY	65	183,231	71,718	255,014	291	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,378	36,736	9,727	49,841	145	65.00
66.00	06600	PHYSICAL THERAPY	343	206,110	20,443	226,896	488	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,389	0	4,389	23	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,274	26,899	34,173	48	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	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	159,093	0	159,093	50	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	243,699	41,282	284,981	447	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)	62,493	4,774,371	1,382,287	6,219,151	4,754	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,589	0	37,589	0	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)	62,493	4,811,960	1,382,287	6,256,740	4,754	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	638,959					5.00
7.00	00700	OPERATION OF PLANT	62,986	1,621,124				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,055	12,751	41,102			8.00
9.00	00900	HOUSEKEEPING	16,411	71,320	0	218,108		9.00
10.00	01000	DIETARY	13,721	95,419	75	13,540	320,451	10.00
11.00	01100	CAFETERIA	13,714	0	128	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,421	4,606	0	654	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,336	52,583	41	7,462	0	14.00
15.00	01500	PHARMACY	17,871	28,906	0	4,102	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,073	40,388	0	5,731	0	16.00
17.00	01700	SOCIAL SERVICE	4,897	0	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	91,273	406,645	12,313	57,701	302,731	30.00
43.00	04300	NURSERY	3,995	8,278	410	1,175	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,148	230,648	4,366	32,729	10,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,042	14,931	498	2,119	0	52.00
53.00	05300	ANESTHESIOLOGY	5,935	6,765	0	960	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,526	167,028	5,390	23,701	0	54.00
60.00	06000	LABORATORY	58,013	100,337	3	14,238	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,956	20,116	0	2,855	0	65.00
66.00	06600	PHYSICAL THERAPY	49,179	112,865	5,596	16,016	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,203	2,403	0	341	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,608	3,983	854	565	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,115	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,701	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,382	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,252	87,119	0	12,362	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	60,354	133,449	10,373	18,936	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)	638,167	1,600,540	40,047	215,187	313,230	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	792	20,584	0	2,921	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,055	0	7,221	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)	638,959	1,621,124	41,102	218,108	320,451	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 9:39 am

		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	54,084					11.00
13.00	01300	NURSING ADMINISTRATION	1,058	24,241				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,596	0	169,057			14.00
15.00	01500	PHARMACY	1,826	0	554	111,039		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,750	0	7	0	142,875	16.00
17.00	01700	SOCIAL SERVICE	632	600	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	10,865	11,118	12,448	0	23,221	30.00
43.00	04300	NURSERY	399	332	195	0	2,340	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,385	4,050	22,668	0	17,297	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	486	404	237	0	987	52.00
53.00	05300	ANESTHESIOLOGY	993	1,062	2,170	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,252	0	9,978	0	3,035	54.00
60.00	06000	LABORATORY	5,715	0	76,039	0	7,533	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,187	0	1,153	0	2,962	65.00
66.00	06600	PHYSICAL THERAPY	6,179	0	2,607	0	2,596	66.00
68.00	06800	SPEECH PATHOLOGY	228	0	0	0	256	68.00
69.00	06900	ELECTROCARDIOLOGY	632	0	427	0	4,242	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,373	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,595	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	111,039	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	665	0	196	0	585	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,236	6,675	15,410	0	76,760	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)	54,084	24,241	169,057	111,039	141,814	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	1,061	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)	54,084	24,241	169,057	111,039	142,875	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 9:39 am

		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	6,183					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,183		1,737,242	0	1,737,242	30.00
43.00	04300	NURSERY	0		35,851	0	35,851	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		1,180,772	0	1,180,772	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		56,357	0	56,357	52.00
53.00	05300	ANESTHESIOLOGY	0		47,666	0	47,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		982,286	0	982,286	54.00
60.00	06000	LABORATORY	0		517,183	0	517,183	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		94,215	0	94,215	65.00
66.00	06600	PHYSICAL THERAPY	0		422,422	0	422,422	66.00
68.00	06800	SPEECH PATHOLOGY	0		9,843	0	9,843	68.00
69.00	06900	ELECTROCARDIOLOGY	0		50,532	0	50,532	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		16,488	0	16,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		14,296	0	14,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		138,421	0	138,421	73.00
76.00	03950	DIABETIC EDUCATION	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		268,322	0	268,322	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		613,621	0	613,621	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)	6,183	0	6,185,517	0	6,185,517	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		61,886	0	61,886	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		9,337	0	9,337	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)	6,183	0	6,256,740	0	6,256,740	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,359,030				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	14,964,733			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	280,606	2,229,067	-7,356,196	30,325,974	5.00
7.00	00700	OPERATION OF PLANT	37,086	39,269	528,967	0	2,989,391	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	34,575	0	239,925	8.00
9.00	00900	HOUSEKEEPING	3,205	0	427,837	0	778,858	9.00
10.00	01000	DIETARY	4,288	22,983	221,018	0	651,214	10.00
11.00	01100	CAFETERIA	0	39,446	379,331	0	650,901	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	282,289	0	447,116	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	930	213,318	0	490,579	14.00
15.00	01500	PHARMACY	1,299	4,738	548,003	0	848,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	535,816	0	905,201	16.00
17.00	01700	SOCIAL SERVICE	0	0	169,186	0	232,422	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,274	46,117	2,105,444	0	4,332,281	30.00
43.00	04300	NURSERY	372	3,518	101,086	0	189,616	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	347,622	960,987	0	2,712,308	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	671	4,274	122,822	0	239,287	52.00
53.00	05300	ANESTHESIOLOGY	304	17,134	0	0	281,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	385,187	1,413,051	0	3,299,777	54.00
60.00	06000	LABORATORY	4,509	70,511	913,706	0	2,753,330	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	9,563	455,204	0	709,835	65.00
66.00	06600	PHYSICAL THERAPY	5,072	20,099	1,536,041	0	2,334,054	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	72,151	0	104,575	68.00
69.00	06900	ELECTROCARDIOLOGY	179	26,446	150,403	0	266,154	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	147,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	128,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,299,584	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	158,508	0	391,626	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	40,587	1,405,923	0	2,864,454	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	1,359,030	14,964,733	-7,356,196	30,288,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	37,589	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)	4,811,960	1,382,287	5,593,275		7,356,196	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.636749	1.017113	0.373764		0.242571	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,754		638,959	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000318		0.021070	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 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 9:39 am

		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	72,851					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	224,907				8.00
9.00	00900	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	4,288	409	4,288	16,909		10.00
11.00	01100	CAFETERIA	0	702	0	0	19,930	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	227	2,363	0	588	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	673	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,382	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	233	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,274	67,377	18,274	15,974	4,003	30.00
43.00	04300	NURSERY	372	2,244	372	0	147	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	23,890	10,365	554	1,616	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	671	2,726	671	0	179	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	366	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	29,491	7,506	0	2,304	54.00
60.00	06000	LABORATORY	4,509	17	4,509	0	2,106	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	806	65.00
66.00	06600	PHYSICAL THERAPY	5,072	30,619	5,072	0	2,277	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	84	68.00
69.00	06900	ELECTROCARDIOLOGY	179	4,674	179	0	233	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	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	245	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	56,760	5,997	0	2,298	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)	71,926	219,136	68,148	16,528	19,930	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,771	0	381	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,714,531	327,340	1,131,203	1,098,636	809,813	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	50.988058	1.455446	16.376920	64.973446	40.632865	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,621,124	41,102	218,108	320,451	54,084	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	22.252598	0.182751	3.157645	18.951505	2.713698	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 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	163,144					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,868,995				14.00
15.00	01500	PHARMACY	0	6,124	1,299,584			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74	0	3,907		16.00
17.00	01700	SOCIAL SERVICE	4,041	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	74,816	137,617	0	635	100	30.00
43.00	04300	NURSERY	2,237	2,159	0	64	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,256	250,610	0	473	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,718	2,624	0	27	0	52.00
53.00	05300	ANESTHESIOLOGY	7,150	23,987	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,308	0	83	0	54.00
60.00	06000	LABORATORY	0	840,635	0	206	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,748	0	81	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,823	0	71	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,723	0	116	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	147,843	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,187	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,299,584	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,164	0	16	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	44,926	170,369	0	2,099	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)	163,144	1,868,995	1,299,584	3,878	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	29	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)	585,365	792,985	1,171,386	1,303,230	312,767	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.588027	0.424284	0.901355	333.562836	3,127.670000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,241	169,057	111,039	142,875	6,183	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.148587	0.090453	0.085442	36.568979	61.830000	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 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 9:39 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	DIABETIC EDUCATION	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-2 | Date/Time Prepared: 2/25/2019 9:39 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY & ANCILLARY	1	30.00	-434,688	7.00
9.00		IV THERAPY	1	64.00	366,088	9.00
10.00		ANCILLARY	1	91.00	68,600	10.00
11.00		DIABETIC EDUCATION	1	30.00	-40,099	11.00
12.00		DIABETIC EDUCATION	1	76.00	40,099	12.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,289,417		8,289,417	0	0	30.00
43.00	04300	NURSERY	300,200		300,200	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,566,802		4,566,802	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	373,645		373,645	0	0	52.00
53.00	05300	ANESTHESIOLOGY	421,187		421,187	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,816,877		4,816,877	0	0	54.00
60.00	06000	LABORATORY	4,235,938		4,235,938	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	366,088		366,088	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,008,096	0	1,008,096	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,414,900	0	3,414,900	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	142,966	0	142,966	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	399,740		399,740	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	246,432		246,432	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	213,669		213,669	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,786,211		2,786,211	0	0	73.00
76.00	03950	DIABETIC EDUCATION	40,099		40,099	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	766,567		766,567	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,141,489		5,141,489	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	382,072		382,072		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,912,395	0	37,912,395	0	0	200.00
201.00		Less Observation Beds	382,072		382,072		0	201.00
202.00		Total (see instructions)	37,530,323	0	37,530,323	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,970,607		4,970,607			30.00
43.00	04300	NURSERY	361,242		361,242			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,007,166	5,886,012	6,893,178	0.662510	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,023,086	529,145	1,552,231	0.240715	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	300,836	938,889	1,239,725	0.339742	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,639	39,249,423	40,051,062	0.120268	0.000000	54.00
60.00	06000	LABORATORY	2,279,401	15,021,625	17,301,026	0.244837	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,155,387	301,694	1,457,081	0.251248	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	681,071	2,252,437	2,933,508	0.343649	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	811,632	5,682,156	6,493,788	0.525872	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	45,469	473,370	518,839	0.275550	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	368,032	2,308,406	2,676,438	0.149355	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,091,793	1,044,904	2,136,697	0.115333	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	425,135	487,820	912,955	0.234041	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,495,328	6,283,716	8,779,044	0.317371	0.000000	73.00
76.00	03950	DIABETIC EDUCATION	0	74,120	74,120	0.541001	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	673	1,054,982	1,055,655	0.726153	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	768,429	16,779,335	17,547,764	0.293000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,164	510,994	530,158	0.720676	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,606,090	98,879,028	117,485,118			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,606,090	98,879,028	117,485,118			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			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
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	03950	DIABETIC EDUCATION	0.000000		76.00
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 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,180,772	6,893,178	0.171296	189,486	32,458	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,357	1,552,231	0.036307	0	0	52.00
53.00	05300	ANESTHESIOLOGY	47,666	1,239,725	0.038449	84,733	3,258	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982,286	40,051,062	0.024526	420,600	10,316	54.00
60.00	06000	LABORATORY	517,183	17,301,026	0.029893	934,034	27,921	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,457,081	0.000000	513,769	0	64.00
65.00	06500	RESPIRATORY THERAPY	94,215	2,933,508	0.032117	354,111	11,373	65.00
66.00	06600	PHYSICAL THERAPY	422,422	6,493,788	0.065050	211,206	13,739	66.00
68.00	06800	SPEECH PATHOLOGY	9,843	518,839	0.018971	26,620	505	68.00
69.00	06900	ELECTROCARDIOLOGY	50,532	2,676,438	0.018880	242,076	4,570	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,488	2,136,697	0.007717	467,090	3,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,296	912,955	0.015659	281,270	4,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,421	8,779,044	0.015767	835,608	13,175	73.00
76.00	03950	DIABETIC EDUCATION	0	74,120	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	268,322	1,055,655	0.254176	155	39	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	613,621	17,547,764	0.034969	147,640	5,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,072	530,158	0.151034	0	0	92.00
200.00		Total (lines 50 through 199)	4,492,496	112,153,269		4,708,398	130,526	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
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	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
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	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 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 9:39 am

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	6,893,178	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,552,231	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,239,725	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,051,062	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,301,026	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,457,081	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,933,508	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,493,788	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	518,839	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,676,438	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,136,697	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	912,955	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,779,044	0.000000	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	74,120	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,055,655	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	17,547,764	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	530,158	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	112,153,269		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	189,486	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	84,733	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	420,600	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	934,034	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	513,769	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	354,111	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	211,206	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	26,620	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	242,076	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	467,090	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	281,270	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	835,608	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	155	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	147,640	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)		4,708,398	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.662510	0	1,733,575	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240715	0	3,050	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339742	0	207,915	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120268	0	13,287,592	0	0	54.00
60.00	06000	LABORATORY	0.244837	0	4,986,545	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.251248	0	95,711	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.343649	0	671,694	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.525872	0	1,811,531	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.275550	0	22,807	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.149355	0	888,575	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115333	0	265,827	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234041	0	128,907	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317371	0	2,910,396	22,369	0	73.00
76.00	03950	DIABETIC EDUCATION	0.541001	0	17,439	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.726153	0	616,812	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.293000	0	5,029,771	4,529	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720676	0	211,874	0	0	92.00
200.00		Subtotal (see instructions)		0	32,890,021	26,898	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	32,890,021	26,898	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,148,511	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	734	0		52.00
53.00	05300	ANESTHESIOLOGY	70,637	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,072	0		54.00
60.00	06000	LABORATORY	1,220,891	0		60.00
64.00	06400	INTRAVENOUS THERAPY	24,047	0		64.00
65.00	06500	RESPIRATORY THERAPY	230,827	0		65.00
66.00	06600	PHYSICAL THERAPY	952,633	0		66.00
68.00	06800	SPEECH PATHOLOGY	6,284	0		68.00
69.00	06900	ELECTROCARDIOLOGY	132,713	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,659	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,170	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	923,675	7,099		73.00
76.00	03950	DIABETIC EDUCATION	9,435	0		76.00
76.97	07697	CARDIAC REHABILITATION	447,900	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,473,723	1,327		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	152,693	0		92.00
200.00		Subtotal (see instructions)	8,453,604	8,426		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,453,604	8,426		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.662510	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240715	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339742	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120268	0	0	0	0	54.00
60.00	06000	LABORATORY	0.244837	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.251248	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.343649	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.525872	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.275550	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.149355	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115333	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234041	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317371	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0.541001	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.726153	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.293000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720676	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
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	03950	DIABETIC EDUCATION	0	0	76.00
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 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,102	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,782	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)	2,596	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	312	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)	936	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	18	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)	54	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,396	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)	202	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)	607	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,289,417	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)	2,797	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)	8,392	25.00
26.00	Total swing-bed cost (see instructions)	2,574,768	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,714,649	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,714,649	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)	2,054.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,867,593	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)	2,867,593	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,267,194	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,134,787	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	414,938	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,246,869	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,661,807	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	186	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,054.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	382,072	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 9:39 am

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	1,737,242	8,289,417	0.209573	382,072	80,072	90.00
91.00	Nursing School cost	0	8,289,417	0.000000	382,072	0	91.00
92.00	Allied health cost	0	8,289,417	0.000000	382,072	0	92.00
93.00	All other Medical Education	0	8,289,417	0.000000	382,072	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 9:39 am

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		2,174,530		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.662510	189,486	125,536	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240715	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339742	84,733	28,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120268	420,600	50,585	54.00
60.00	06000	LABORATORY	0.244837	934,034	228,686	60.00
64.00	06400	INTRAVENOUS THERAPY	0.251248	513,769	129,083	64.00
65.00	06500	RESPIRATORY THERAPY	0.343649	354,111	121,690	65.00
66.00	06600	PHYSICAL THERAPY	0.525872	211,206	111,067	66.00
68.00	06800	SPEECH PATHOLOGY	0.275550	26,620	7,335	68.00
69.00	06900	ELECTROCARDIOLOGY	0.149355	242,076	36,155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115333	467,090	53,871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234041	281,270	65,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317371	835,608	265,198	73.00
76.00	03950	DIABETIC EDUCATION	0.541001	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.726153	155	113	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.293000	147,640	43,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720676	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,708,398	1,267,194	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)		4,708,398		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.662510	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240715	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339742	346	118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120268	61,944	7,450	54.00
60.00	06000	LABORATORY	0.244837	194,860	47,709	60.00
64.00	06400	INTRAVENOUS THERAPY	0.251248	216,043	54,280	64.00
65.00	06500	RESPIRATORY THERAPY	0.343649	102,350	35,172	65.00
66.00	06600	PHYSICAL THERAPY	0.525872	290,924	152,989	66.00
68.00	06800	SPEECH PATHOLOGY	0.275550	9,857	2,716	68.00
69.00	06900	ELECTROCARDIOLOGY	0.149355	3,705	553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115333	138,474	15,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234041	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317371	439,210	139,393	73.00
76.00	03950	DIABETIC EDUCATION	0.541001	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.726153	45	33	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.293000	97,614	28,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720676	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,555,372	484,985	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,555,372		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1322	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/25/2019 9:39 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,462,030	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)	8,462,030	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)	8,546,650	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)	55,517	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,553,391	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)	2,937,742	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)	2,937,742	30.00
31.00	Primary payer payments	265	31.00
32.00	Subtotal (line 30 minus line 31)	2,937,477	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)	706,549	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	459,257	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	643,494	36.00
37.00	Subtotal (see instructions)	3,396,734	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)	3,396,734	40.00
40.01	Sequestration adjustment (see instructions)	67,935	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,619,120	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-290,321	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 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,675,862		3,595,325	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/12/2018	131,474	04/12/2018	23,795	3.01
3.02		08/22/2018	52,660		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		184,134		23,795	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)		3,859,996		3,619,120	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		116,324		290,321	6.02
7.00	Total Medicare program liability (see instructions)		3,743,672		3,328,799	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 | Component CCN: 14-Z322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,170,860		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/12/2018	40,902		0	3.01
3.02		08/22/2018	11,447		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		52,349		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)		2,223,209		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		117,804		0	6.02
7.00	Total Medicare program liability (see instructions)		2,105,405		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 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/25/2019 9:39 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-2 | Date/Time Prepared: 2/25/2019 9:39 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,678,425	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)	489,835	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	809	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)	2,168,260	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,168,260	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)	2,168,260	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,888	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)	2,148,372	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)	2,148,372	0	19.00
19.01	Sequestration adjustment (see instructions)	42,967	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,223,209	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)	-117,804	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 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/25/2019 9:39 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,134,787	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,134,787	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,176,135	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,176,135	19.00
20.00	Deductibles (exclude professional component)	387,972	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,788,163	22.00
23.00	Coinsurance	6,359	23.00
24.00	Subtotal (line 22 minus line 23)	3,781,804	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	58,875	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	38,269	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	54,879	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,820,073	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)	3,820,073	30.00
30.01	Sequestration adjustment (see instructions)	76,401	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,859,996	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)	-116,324	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 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 2/25/2019 9:39 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	15,064,202	0	0	0	1.00
2.00	Temporary investments	23,971,059	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,305,504	0	0	0	4.00
5.00	Other receivable	108,908	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,489,368	0	0	0	6.00
7.00	Inventory	602,753	0	0	0	7.00
8.00	Prepaid expenses	252,816	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	42,617	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	44,858,491	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,454,817	0	0	0	12.00
13.00	Land improvements	6,071,397	0	0	0	13.00
14.00	Accumulated depreciation	-3,830,565	0	0	0	14.00
15.00	Buildings	42,607,743	0	0	0	15.00
16.00	Accumulated depreciation	-19,848,196	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	16,897,877	0	0	0	23.00
24.00	Accumulated depreciation	-12,033,655	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	174,853	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	31,494,271	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	66,497,660	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	127,281	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	66,624,941	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	142,977,703	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	850,784	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,836,332	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	459,680	0	0	0	40.00
41.00	Deferred income	1,119,567	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-148,091	0	0	0	43.00
44.00	Other current liabilities	570,850	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,689,122	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	41,003,192	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	517,834	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,521,026	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,210,148	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	96,767,555				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)	96,767,555	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	142,977,703	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/25/2019 9:39 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		84,233,184		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,534,371				2.00
3.00	Total (sum of line 1 and line 2)		96,767,555		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)		96,767,555		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)		96,767,555		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 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2019 9:39 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,384,748		3,384,748	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,499,357		1,499,357	5.00
6.00	Swing bed - NF	86,501		86,501	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)	4,970,606		4,970,606	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)	4,970,606		4,970,606	17.00
18.00	Ancillary services	12,486,648	81,588,699	94,075,347	18.00
19.00	Outpatient services	787,593	17,290,329	18,077,922	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	361,242	0	361,242	27.00
27.01	PRO FEES	856,901	14,336,125	15,193,026	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,462,990	113,215,153	132,678,143	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,289,478		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)		44,289,478		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 2/25/2019 9:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	132,678,143	1.00
2.00	Less contractual allowances and discounts on patients' accounts	84,654,275	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,023,868	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,289,478	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,734,390	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	60,224	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	167,667	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	664	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	5,868	22.00
23.00	Governmental appropriations	4,160,083	23.00
24.00	MANAGEMENT SUPPORT	16,800	24.00
24.01	SALE OF REFUSE	33,354	24.01
24.02	NET INVESTMENT INCOME	4,857,956	24.02
24.03	MISCELLANEOUS INCOME	89,385	24.03
25.00	Total other income (sum of lines 6-24)	9,392,001	25.00
26.00	Total (line 5 plus line 25)	13,126,391	26.00
27.00	LOSS ON DISPOSAL OF FIXED ASSETS	92,020	27.00
27.01	CONTRIBUTION EXPENSE	500,000	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	592,020	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,534,371	29.00