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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/25/2020 11:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2020 Time: 11:43 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 DEKALB MEMORIAL HOSPITAL (15-0045) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)______________________________
Officer or Administrator of Provider(s)

____
Title

____
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	198,413	56,612	0	-281,811	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	198,413	56,612	0	-281,811	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 11:43 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1316 EAST 7TH STREET	PO Box:			1.00
2.00	City: AUBURN	State: IN	Zip Code: 46706-	County: DEKALB	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	DEKALB MEMORIAL HOSPITAL	150045	99915	1	07/01/1966	N	P	O	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									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	DEKALB HOME HEALTH AGENCY	157157	99915		07/09/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	DEKALB HOSPICE	151559	99915		11/06/1996				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
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 11:43 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	
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.	159	450	0	8	461	0	24.00
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)	Y	Y	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 11:43 am

		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

		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

		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

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2020 11:43 am

		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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	290,679	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			

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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
161.10	CORF		N	N	N	161.10

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 11:43 am

		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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2020 11:43 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	11/29/2018	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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/17/2019	Y	12/17/2019	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

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/25/2020 11:43 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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2020 11:43 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	29	10,585	0.00	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)		29	10,585	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		37	13,505	0.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		37				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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2020 11:43 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)	1,106	158	3,222			1.00
2.00	HMO and other (see instructions)	1,167	902				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,106	158	3,222			7.00
8.00	INTENSIVE CARE UNIT	282	0	1,122			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		0	673			13.00
14.00	Total (see instructions)	1,388	158	5,017	0.00	466.97	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	2,209	0	6,403	0.00	12.21	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	1.12	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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	480.30	27.00
28.00	Observation Bed Days		0	2,309			28.00
29.00	Ambulance Trips	1,003					29.00
30.00	Employee discount days (see instruction)			54			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	18	32			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

	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	473	42	1,672	1.00
2.00	HMO and other (see instructions)			374	272		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	473	42	1,672	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
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

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	28,584,062	0	28,584,062	980,965.00	29.14	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		171,031	0	171,031	1,208.00	141.58	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		9,822,061	-21,031	9,801,030	290,986.00	33.68	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		168,987	0	168,987	2,487.00	67.95	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		680,452	0	680,452	4,450.00	152.91	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,535,492	0	6,535,492			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,822,834	0	2,822,834			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		18,532	0	18,532			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	198,807	0	198,807	6,133.00	32.42	26.00
27.00	Administrative & General	5.00	4,129,630	0	4,129,630	154,165.00	26.79	27.00
28.00	Administrative & General under contract (see inst.)		420,959	0	420,959	1,838.00	229.03	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	613,519	0	613,519	23,519.00	26.09	30.00
31.00	Laundry & Linen Service	8.00	0	29,999	29,999	1,657.00	18.10	31.00
32.00	Housekeeping	9.00	859,120	0	859,120	57,211.00	15.02	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	496,202	-385,352	110,850	6,365.00	17.42	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	355,353	355,353	22,187.00	16.02	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	505,591	0	505,591	13,588.00	37.21	38.00
39.00	Central Services and Supply	14.00	102,560	0	102,560	5,886.00	17.42	39.00
40.00	Pharmacy	15.00	591,122	0	591,122	13,162.00	44.91	40.00
41.00	Medical Records & Medical Records Library	16.00	215,593	0	215,593	14,444.00	14.93	41.00
42.00	Social Service	17.00	73,384	0	73,384	2,080.00	35.28	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part III Date/Time Prepared: 2/25/2020 11:43 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		29,005,021	0	29,005,021	982,803.00	29.51	1.00
2.00	Excluded area salaries (see instructions)		9,822,061	-21,031	9,801,030	290,986.00	33.68	2.00
3.00	Subtotal salaries (line 1 minus line 2)		19,182,960	21,031	19,203,991	691,817.00	27.76	3.00
4.00	Subtotal other wages & related costs (see inst.)		849,439	0	849,439	6,937.00	122.45	4.00
5.00	Subtotal wage-related costs (see inst.)		6,554,024	0	6,554,024	0.00	34.13	5.00
6.00	Total (sum of lines 3 thru 5)		26,586,423	21,031	26,607,454	698,754.00	38.08	6.00
7.00	Total overhead cost (see instructions)		8,206,487	0	8,206,487	322,235.00	25.47	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/25/2020 11:43 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	122,454	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	5,995,787	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	517,832	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	92,635	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,415,937	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	232,214	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,376,859	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part V | Date/Time Prepared: 2/25/2020 11:43 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	168,987	9,376,859	1.00
2.00	Hospital	168,987	9,376,859	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet S-4
Component CCN: 15-7157		Date/Time Prepared: 2/25/2020 11:43 am
	Home Health Agency I	PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	106.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.94	0.00	0.94	4.00
5.00	Other Administrative Personnel		1.83	0.00	1.83	5.00
6.00	Direct Nursing Service		4.23	0.00	4.23	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.65	0.00	1.65	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.62	0.00	0.62	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.05	0.00	0.05	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.53	0.00	0.53	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		1.66	0.00	1.66	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		34620			20.00
20.01			99915			20.01

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	831	258	27	13	1,129	21.00
22.00	Skilled Nursing Visit Charges	183,797	57,033	5,991	2,891	249,712	22.00
23.00	Physical Therapy Visits	318	89	8	16	431	23.00
24.00	Physical Therapy Visit Charges	108,463	30,348	2,734	5,449	146,994	24.00
25.00	Occupational Therapy Visits	92	80	0	5	177	25.00
26.00	Occupational Therapy Visit Charges	31,552	27,456	0	1,716	60,724	26.00
27.00	Speech Pathology Visits	2	10	0	0	12	27.00
28.00	Speech Pathology Visit Charges	700	3,399	0	0	4,099	28.00
29.00	Medical Social Service Visits	24	16	0	0	40	29.00
30.00	Medical Social Service Visit Charges	8,070	5,406	0	0	13,476	30.00
31.00	Home Health Aide Visits	295	120	0	5	420	31.00
32.00	Home Health Aide Visit Charges	38,738	15,840	0	660	55,238	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,562	573	35	39	2,209	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	371,320	139,482	8,725	10,716	530,243	35.00
36.00	Total Number of Episodes (standard/non outlier)	103		13	2	118	36.00
37.00	Total Number of Outlier Episodes		17		1	18	37.00
38.00	Total Non-Routine Medical Supply Charges	12,291	3,553	0	94	15,938	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	2,607	0	24	2,631	11.00
12.00	Hospice Inpatient Respite Care	31	0	0	31	12.00
13.00	Hospice General Inpatient Care	10	0	2	12	13.00
14.00	Total Hospice Days	2,648	0	26	2,674	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-10 | Date/Time Prepared: 2/25/2020 11:43 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)	0.244586	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	870,312	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	21,311,710	6.00
7.00	Medicaid cost (line 1 times line 6)	5,212,546	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)	4,342,234	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,342,234	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)	3,572,141	183,973	3,756,114	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	873,696	183,973	1,057,669	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	873,696	183,973	1,057,669	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)	9,440,398	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	62,033	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	95,436	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,344,962	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,319,050	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,376,719	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,718,953	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/25/2020 11:43 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		4,716,053	4,716,053	0	4,716,053	1.00
1.01	00101	MOB WEST		34,169	34,169	0	34,169	1.01
1.02	00102	NORTH ANNEX		5,337	5,337	0	5,337	1.02
1.03	00103	GARRETT CLINIC		27,336	27,336	0	27,336	1.03
1.04	00104	BUTLER		8,816	8,816	0	8,816	1.04
1.05	00105	MOB EAST		192,000	192,000	0	192,000	1.05
1.07	00107	MEDICAL ARTS		66,060	66,060	0	66,060	1.07
1.08	00108	SMALTZ WAY		4,996	4,996	0	4,996	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	198,807	7,439,206	7,638,013	0	7,638,013	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,129,630	7,704,279	11,833,909	-5,246	11,828,663	5.00
7.00	00700	OPERATION OF PLANT	613,519	1,762,839	2,376,358	0	2,376,358	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	29,999	29,999	8.00
9.00	00900	HOUSEKEEPING	859,120	406,731	1,265,851	0	1,265,851	9.00
10.00	01000	DIETARY	496,202	396,309	892,511	-692,320	200,191	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	662,321	662,321	11.00
13.00	01300	NURSING ADMINISTRATION	505,591	71,630	577,221	0	577,221	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	102,560	125,906	228,466	0	228,466	14.00
15.00	01500	PHARMACY	591,122	43,424	634,546	0	634,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	215,593	53,277	268,870	0	268,870	16.00
17.00	01700	SOCIAL SERVICE	73,384	5,623	79,007	0	79,007	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,580,788	553,819	3,134,607	-744,953	2,389,654	30.00
31.00	03100	INTENSIVE CARE UNIT	1,003,425	341,403	1,344,828	0	1,344,828	31.00
43.00	04300	NURSERY	0	0	0	206,170	206,170	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,686,601	1,378,969	3,065,570	0	3,065,570	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	538,783	538,783	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,769,774	709,328	2,479,102	0	2,479,102	54.00
60.00	06000	LABORATORY	1,189,354	1,802,593	2,991,947	0	2,991,947	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	611,602	107,690	719,292	0	719,292	65.00
66.00	06600	PHYSICAL THERAPY	297,908	992,040	1,289,948	0	1,289,948	66.00
66.01	06601	CARDIAC REHAB	144,121	19,583	163,704	21,031	184,735	66.01
69.00	06900	ELECTROCARDIOLOGY	139,662	10,922	150,584	0	150,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35,396	21,981	57,377	0	57,377	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,553,673	1,553,673	0	1,553,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	970,613	970,613	0	970,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,352,485	3,352,485	0	3,352,485	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,019	37,209	91,228	0	91,228	90.00
91.00	09100	EMERGENCY	1,463,823	203,753	1,667,576	0	1,667,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,221,686	335,226	1,556,912	0	1,556,912	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	694,164	140,343	834,507	0	834,507	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	127,312	300,072	427,384	0	427,384	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,805,163	35,895,693	56,700,856	15,785	56,716,641	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	6,720,836	1,083,918	7,804,754	-15,785	7,788,969	192.01
192.02	19202	PHARMACARE	816,038	6,182,465	6,998,503	0	6,998,503	192.02
192.03	19203	OUTSOURCED DIETICIAN	31,855	2,426	34,281	0	34,281	192.03
192.04	19204	BUSINESS HEALTH	143,726	81,813	225,539	0	225,539	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	66,444	79,074	145,518	0	145,518	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	28,584,062	43,325,389	71,909,451	0	71,909,451	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/25/2020 11:43 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	-367,144	4,348,909	1.00
1.01	00101	MOB WEST	-34,169	0	1.01
1.02	00102	NORTH ANNEX	-5,337	0	1.02
1.03	00103	GARRETT CLINIC	-27,336	0	1.03
1.04	00104	BUTLER	0	8,816	1.04
1.05	00105	MOB EAST	-192,000	0	1.05
1.07	00107	MEDICAL ARTS	0	66,060	1.07
1.08	00108	SMALTZ WAY	0	4,996	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-608,475	7,029,538	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,111,066	7,717,597	5.00
7.00	00700	OPERATION OF PLANT	-3,497	2,372,861	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,999	8.00
9.00	00900	HOUSEKEEPING	-528	1,265,323	9.00
10.00	01000	DIETARY	0	200,191	10.00
10.01	01001	SNACK BAR	0	0	10.01
11.00	01100	CAFETERIA	-251,656	410,665	11.00
13.00	01300	NURSING ADMINISTRATION	0	577,221	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	228,466	14.00
15.00	01500	PHARMACY	0	634,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,034	267,836	16.00
17.00	01700	SOCIAL SERVICE	0	79,007	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-7,719	2,381,935	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,719	1,337,109	31.00
43.00	04300	NURSERY	0	206,170	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-858,934	2,206,636	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	538,783	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-33,182	2,445,920	54.00
60.00	06000	LABORATORY	-11,704	2,980,243	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	719,292	65.00
66.00	06600	PHYSICAL THERAPY	-16,491	1,273,457	66.00
66.01	06601	CARDIAC REHAB	-11,264	173,471	66.01
69.00	06900	ELECTROCARDIOLOGY	0	150,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	57,377	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,553,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	970,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-9,450	3,343,035	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	91,228	90.00
91.00	09100	EMERGENCY	0	1,667,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-250,746	1,306,166	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-172	834,335	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-98	427,286	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,809,721	49,906,920	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	7,788,969	192.01
192.02	19202	PHARMACARE	0	6,998,503	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	34,281	192.03
192.04	19204	BUSINESS HEALTH	0	225,539	192.04
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	194.01
194.02	07952	FOUNDATION	0	145,518	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,809,721	65,099,730	200.00

RECLASSIFICATIONS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 11:43 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	355,353	306,968	1.00
	0		355,353	306,968	
	B - LABOR DELIVERY NURSERY				
1.00	NURSERY	43.00	177,282	28,888	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	463,291	75,492	2.00
	0		640,573	104,380	
	C - NORTH ANNEX RECLASS				
1.00	DEKALB MEDICAL SERVICES	192.01	0	5,246	1.00
	0		0	5,246	
	E - PHYSICIAN RECLASS				
1.00	CARDIAC REHAB	66.01	21,031	0	1.00
	0		21,031	0	
	F - LAUNDRY SALARY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	29,999	0	1.00
	0		29,999	0	
500.00	Grand Total: Increases		1,046,956	416,594	500.00

RECLASSIFICATIONS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 Date/Time Prepared: 2/25/2020 11:43 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	355,353	306,968	0	1.00
	0		355,353	306,968		
	B - LABOR DELIVERY NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	640,573	104,380	0	1.00
2.00		0.00	0	0	0	2.00
	0		640,573	104,380		
	C - NORTH ANNEX RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,246	0	1.00
	0		0	5,246		
	E - PHYSICIAN RECLASS					
1.00	DEKALB MEDICAL SERVICES	192.01	21,031	0	0	1.00
	0		21,031	0		
	F - LAUNDRY SALARY RECLASS					
1.00	DIETARY	10.00	29,999	0	0	1.00
	0		29,999	0		
500.00	Grand Total: Decreases		1,046,956	416,594		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2020 11:43 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	393,118	0	0	0	45,326	1.00
2.00	Land Improvements	1,808,464	49,450	0	49,450	0	2.00
3.00	Buildings and Fixtures	61,162,990	155,060	0	155,060	0	3.00
4.00	Building Improvements	203,151	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	27,312,434	1,845,676	0	1,845,676	582,826	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	90,880,157	2,050,186	0	2,050,186	628,152	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	90,880,157	2,050,186	0	2,050,186	628,152	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	347,792	0	1.00
2.00	Land Improvements	1,857,914	0	2.00
3.00	Buildings and Fixtures	61,318,050	0	3.00
4.00	Building Improvements	203,151	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	28,575,284	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	92,302,191	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	92,302,191	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2020 11:43 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	4,372,322	0	343,731	0	0	1.00
1.01	MOB WEST	34,169	0	0	0	0	1.01
1.02	NORTH ANNEX	5,337	0	0	0	0	1.02
1.03	GARRETT CLINIC	27,336	0	0	0	0	1.03
1.04	BUTLER	8,816	0	0	0	0	1.04
1.05	MOB EAST	192,000	0	0	0	0	1.05
1.07	MEDICAL ARTS	66,060	0	0	0	0	1.07
1.08	SMALTZ WAY	4,996	0	0	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,711,036	0	343,731	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	4,716,053	1.00
1.01	MOB WEST	0	34,169	1.01
1.02	NORTH ANNEX	0	5,337	1.02
1.03	GARRETT CLINIC	0	27,336	1.03
1.04	BUTLER	0	8,816	1.04
1.05	MOB EAST	0	192,000	1.05
1.07	MEDICAL ARTS	0	66,060	1.07
1.08	SMALTZ WAY	0	4,996	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	5,054,767	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2020 11:43 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	92,302,191	0	92,302,191	1.000000	0	1.00
1.01	MOB WEST	0	0	0	0.000000	0	1.01
1.02	NORTH ANNEX	0	0	0	0.000000	0	1.02
1.03	GARRETT CLINIC	0	0	0	0.000000	0	1.03
1.04	BUTLER	0	0	0	0.000000	0	1.04
1.05	MOB EAST	0	0	0	0.000000	0	1.05
1.07	MEDICAL ARTS	0	0	0	0.000000	0	1.07
1.08	SMALTZ WAY	0	0	0	0.000000	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	92,302,191	0	92,302,191	1.000000	0	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	0	4,348,909	0	1.00
1.01	MOB WEST	0	0	0	0	0	1.01
1.02	NORTH ANNEX	0	0	0	0	0	1.02
1.03	GARRETT CLINIC	0	0	0	0	0	1.03
1.04	BUTLER	0	0	0	8,816	0	1.04
1.05	MOB EAST	0	0	0	0	0	1.05
1.07	MEDICAL ARTS	0	0	0	66,060	0	1.07
1.08	SMALTZ WAY	0	0	0	4,996	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,428,781	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	4,348,909	1.00
1.01	MOB WEST	0	0	0	0	0	1.01
1.02	NORTH ANNEX	0	0	0	0	0	1.02
1.03	GARRETT CLINIC	0	0	0	0	0	1.03
1.04	BUTLER	0	0	0	0	8,816	1.04
1.05	MOB EAST	0	0	0	0	0	1.05
1.07	MEDICAL ARTS	0	0	0	0	66,060	1.07
1.08	SMALTZ WAY	0	0	0	0	4,996	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,428,781	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/25/2020 11:43 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	-343,731	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - MOB WEST (chapter 2)		0	MOB WEST	1.01	0	1.01
1.02	Investment income - NORTH ANNEX (chapter 2)		0	NORTH ANNEX	1.02	0	1.02
1.03	Investment income - GARRETT CLINIC (chapter 2)		0	GARRETT CLINIC	1.03	0	1.03
1.04	Investment income - BUTLER (chapter 2)		0	BUTLER	1.04	0	1.04
1.05	Investment income - MOB EAST (chapter 2)		0	MOB EAST	1.05	0	1.05
1.07	Investment income - MEDICAL ARTS (chapter 2)		0	MEDICAL ARTS	1.07	0	1.07
1.08	Investment income - SMALTZ WAY (chapter 2)		0	SMALTZ WAY	1.08	0	1.08
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-906,797			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-251,656	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	B	-9,450	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,034	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

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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
26.01	Depreciation - MOB WEST		0	MOB WEST	1.01	0	26.01
26.02	Depreciation - NORTH ANNEX		0	NORTH ANNEX	1.02	0	26.02
26.03	Depreciation - GARRETT CLINIC		0	GARRETT CLINIC	1.03	0	26.03
26.04	Depreciation - BUTLER		0	BUTLER	1.04	0	26.04
26.05	Depreciation - MOB EAST		0	MOB EAST	1.05	0	26.05
26.07	Depreciation - MEDICAL ARTS		0	MEDICAL ARTS	1.07	0	26.07
26.08	Depreciation - SMALTZ WAY		0	SMALTZ WAY	1.08	0	26.08
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC HUMAN RESOURCE REVENUE	B	2,597	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-213,531	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC. MAINTENANCE INCOME	B	-3,497	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC. HOUSEKEEPING INCOME	B	-528	HOUSEKEEPING	9.00	0	33.03
33.04	MISC SUGERY REVENUE	B	-472	OPERATING ROOM	50.00	0	33.04
33.05	MISC X-RAY REVENUE	B	-285	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MISC LAB REVENUE	B	-11,704	LABORATORY	60.00	0	33.06
33.07	MISC. ST REVENUE	B	-16,491	PHYSICAL THERAPY	66.00	0	33.07
33.08	MISC. CARDIAC REHAB REVENUE	B	-11,264	CARDIAC REHAB	66.01	0	33.08
33.09	EMS COUNTY SUBSIDY	B	-250,746	AMBULANCE SERVICES	95.00	0	33.09
33.10	RENTAL INCOME	B	-34,169	MOB WEST	1.01	9	33.10
33.11	RENTAL INCOME	B	-192,000	MOB EAST	1.05	9	33.11
33.12	RENTAL INCOME	B	-5,337	NORTH ANNEX	1.02	9	33.12
33.13	RENTAL INCOME	B	-27,336	GARRETT CLINIC	1.03	9	33.13
33.14	RENTAL INCOME	B	-23,413	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.15	NON-ALLOWABLE MARKETING	A	-297,276	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	LOBBYING PORTION OF IAHHC DUES - HOS	A	-74	HOSPICE	116.00	0	33.16
33.17	FLOWER/GIFTS	A	-24	HOSPICE	116.00	0	33.17
33.18	FLOWER/GIFTS	A	-4,070	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HAF FEE	A	-3,427,195	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	SELF-INSURANCE EXP	A	-611,072	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	DONATION EXPENSE	A	-168,994	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	LOBBYING PORTION OF IAHHC DUES - HHA	A	-172	HOME HEALTH AGENCY	101.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,809,721				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
  A. Costs - if cost, including applicable overhead, can be determined.
  B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2020 11:43 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	54.00	RADIOLOGY-DIAGNOSTIC	32,897	32,897	0	271,900	0	1.00
2.00	50.00	OPERATING ROOM	638,809	638,809	0	239,400	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	2,673	0	2,673	239,400	81	3.00
4.00	30.00	ADULTS & PEDIATRICS	153,375	0	153,375	197,500	1,534	4.00
5.00	31.00	INTENSIVE CARE UNIT	153,375	0	153,375	197,500	1,534	5.00
6.00	50.00	OPERATING ROOM	714	0	714	197,500	18	6.00
7.00	50.00	OPERATING ROOM	254,500	0	254,500	197,500	367	7.00
8.00	50.00	OPERATING ROOM	22,875	0	22,875	211,500	229	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,259,218	671,706	587,512		3,763	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	9,323	466	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	145,656	7,283	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	145,656	7,283	0	0	0	5.00
6.00	50.00	OPERATING ROOM	1,709	85	0	0	0	6.00
7.00	50.00	OPERATING ROOM	34,847	1,742	0	0	0	7.00
8.00	50.00	OPERATING ROOM	23,285	1,164	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			360,476	18,023	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	32,897		1.00
2.00	50.00	OPERATING ROOM	0	0	0	638,809		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	9,323	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	145,656	7,719	7,719		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	145,656	7,719	7,719		5.00
6.00	50.00	OPERATING ROOM	0	1,709	0	0		6.00
7.00	50.00	OPERATING ROOM	0	34,847	219,653	219,653		7.00
8.00	50.00	OPERATING ROOM	0	23,285	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	360,476	235,091	906,797		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT CLINIC	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,348,909	4,348,909				1.00
1.01	00101	MOB WEST	0	0	0			1.01
1.02	00102	NORTH ANNEX	0	0	0	0		1.02
1.03	00103	GARRETT CLINIC	0	0	0	0	0	1.03
1.04	00104	BUTLER	8,816	0	0	0	0	1.04
1.05	00105	MOB EAST	0	0	0	0	0	1.05
1.07	00107	MEDICAL ARTS	66,060	0	0	0	0	1.07
1.08	00108	SMALTZ WAY	4,996	0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,029,538	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,717,597	456,179	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,372,861	1,751,395	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,999	26,077	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,265,323	41,693	0	0	0	9.00
10.00	01000	DIETARY	200,191	21,884	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	410,665	67,530	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	577,221	23,151	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	228,466	27,497	0	0	0	14.00
15.00	01500	PHARMACY	634,546	25,291	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	267,836	28,349	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	79,007	3,582	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,381,935	256,100	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,337,109	108,743	0	0	0	31.00
43.00	04300	NURSERY	206,170	19,482	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,206,636	387,469	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	538,783	301,309	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,445,920	203,443	0	0	0	54.00
60.00	06000	LABORATORY	2,980,243	91,489	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	719,292	23,850	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,273,457	113,919	0	0	0	66.00
66.01	06601	CARDIAC REHAB	173,471	59,952	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	150,584	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	57,377	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,553,673	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	970,613	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,343,035	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	91,228	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,667,576	168,083	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,306,166	17,931	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	834,335	6,552	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	427,286	6,552	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,906,920	4,237,502	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	7,788,969	111,407	0	0	0	192.01
192.02	19202	PHARMACARE	6,998,503	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	34,281	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	225,539	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	145,518	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	65,099,730	4,348,909	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BUTLER	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	
			1.04	1.05	1.07	1.08	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER	8,816					1.04
1.05	00105	MOB EAST	0	0				1.05
1.07	00107	MEDICAL ARTS	0	0	66,060			1.07
1.08	00108	SMALTZ WAY	0	0	0	4,996		1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	0	6,217	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	624	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	624	0	6,217	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	8,192	0	59,843	4,996	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	8,816	0	66,060	4,996	0	202.00

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,029,538					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,022,695	9,196,471	9,196,471			5.00
7.00	00700	OPERATION OF PLANT	151,937	4,282,410	704,486	4,986,896		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,429	63,505	10,447	39,731	113,683	8.00
9.00	00900	HOUSEKEEPING	212,759	1,519,775	250,014	66,052	4,726	9.00
10.00	01000	DIETARY	27,452	249,527	41,049	40,130	794	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	88,002	566,197	93,143	102,888	0	11.00
13.00	01300	NURSING ADMINISTRATION	125,209	725,581	119,363	35,272	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,399	281,362	46,286	41,894	0	14.00
15.00	01500	PHARMACY	146,390	806,227	132,630	38,533	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,391	349,576	57,508	52,642	0	16.00
17.00	01700	SOCIAL SERVICE	18,173	100,762	16,576	5,457	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	480,490	3,118,525	513,019	390,191	23,007	30.00
31.00	03100	INTENSIVE CARE UNIT	248,496	1,694,348	278,732	165,680	9,853	31.00
43.00	04300	NURSERY	43,904	269,556	44,344	29,682	1,617	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	417,683	3,011,788	495,460	590,344	20,282	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	114,733	954,825	157,075	459,072	4,410	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	438,281	3,087,644	507,939	309,963	13,295	54.00
60.00	06000	LABORATORY	294,541	3,366,897	553,878	177,193	69	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	151,462	894,604	147,169	36,337	0	65.00
66.00	06600	PHYSICAL THERAPY	73,776	1,461,152	240,370	173,566	2,299	66.00
66.01	06601	CARDIAC REHAB	40,900	274,323	45,128	91,342	645	66.01
69.00	06900	ELECTROCARDIOLOGY	34,587	185,171	30,462	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,766	66,143	10,881	0	848	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,553,673	255,590	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	970,613	159,673	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,343,035	549,953	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,378	104,606	17,208	0	897	90.00
91.00	09100	EMERGENCY	362,513	2,198,172	361,615	256,090	24,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	302,548	1,626,645	267,594	27,319	4,091	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	171,908	1,012,795	166,612	9,983	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	31,529	465,367	76,556	9,983	89	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,108,331	47,801,275	6,350,760	3,149,344	111,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	1,659,180	9,632,587	1,584,622	1,837,552	1,394	192.01
192.02	19202	PHARMACARE	202,090	7,200,593	1,184,548	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	7,889	42,170	6,937	0	0	192.03
192.04	19204	BUSINESS HEALTH	35,593	261,132	42,958	0	508	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	16,455	161,973	26,646	0	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,029,538	65,099,730	9,196,471	4,986,896	113,683	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	NURSING ADMINISTRATION	
			9.00	10.00	10.01	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
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	1,840,567					9.00
10.00	01000	DIETARY	15,132	346,632				10.00
10.01	01001	SNACK BAR	0	0	0			10.01
11.00	01100	CAFETERIA	38,797	0	0	801,025		11.00
13.00	01300	NURSING ADMINISTRATION	13,300	0	0	16,097	909,613	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,797	0	0	6,976	20,581	14.00
15.00	01500	PHARMACY	14,530	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,850	0	0	17,108	0	16.00
17.00	01700	SOCIAL SERVICE	2,058	0	0	2,465	7,273	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	147,133	258,542	0	74,815	220,703	30.00
31.00	03100	INTENSIVE CARE UNIT	62,474	88,090	0	36,286	107,053	31.00
43.00	04300	NURSERY	11,192	0	0	6,113	18,053	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	222,607	0	0	61,356	181,029	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	173,106	0	0	15,998	47,179	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,881	0	0	71,684	0	54.00
60.00	06000	LABORATORY	66,816	0	0	57,461	14,000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,702	0	0	24,823	0	65.00
66.00	06600	PHYSICAL THERAPY	65,448	0	0	13,607	0	66.00
66.01	06601	CARDIAC REHAB	34,443	0	0	7,420	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,472	16,136	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,750	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	15,604	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,553	4,598	90.00
91.00	09100	EMERGENCY	96,566	0	0	59,655	176,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,302	0	0	66,557	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,764	0	0	30,099	88,822	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,764	0	0	2,761	8,168	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,147,662	346,632	0	595,660	909,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	692,905	0	0	177,781	0	192.01
192.02	19202	PHARMACARE	0	0	0	25,464	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	2,120	0	194.02
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)	1,840,567	346,632	0	801,025	909,613	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
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
10.01	01001	SNACK BAR						10.01
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	412,896					14.00
15.00	01500	PHARMACY	0	991,920				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	496,684			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	134,591		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	27,792	134,591	4,908,318	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	13,712	0	2,456,228	31.00
43.00	04300	NURSERY	0	0	2,733	0	383,290	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	86,577	0	4,669,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	7,141	0	1,818,806	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	90,818	0	4,198,224	54.00
60.00	06000	LABORATORY	0	0	72,747	0	4,309,061	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	13,393	0	1,130,028	65.00
66.00	06600	PHYSICAL THERAPY	0	0	18,000	0	1,974,442	66.00
66.01	06601	CARDIAC REHAB	0	0	1,807	0	455,108	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	917	0	238,158	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,528	0	82,150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	412,896	0	26,458	0	2,264,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,130,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	991,920	20,261	0	4,905,169	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	847	0	129,709	90.00
91.00	09100	EMERGENCY	0	0	54,670	0	3,227,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,002,508	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	1,312,075	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	269	0	566,957	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,896	991,920	440,670	134,591	42,161,826	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	43,746	0	13,970,587	192.01
192.02	19202	PHARMACARE	0	0	12,268	0	8,422,873	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	49,107	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	304,598	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	190,739	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	412,896	991,920	496,684	134,591	65,099,730	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB WEST			1.01
1.02	00102	NORTH ANNEX			1.02
1.03	00103	GARRETT CLINIC			1.03
1.04	00104	BUTLER			1.04
1.05	00105	MOB EAST			1.05
1.07	00107	MEDICAL ARTS			1.07
1.08	00108	SMALTZ WAY			1.08
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
10.01	01001	SNACK BAR			10.01
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	4,908,318	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,456,228	31.00
43.00	04300	NURSERY	0	383,290	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	4,669,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,818,806	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,198,224	54.00
60.00	06000	LABORATORY	0	4,309,061	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,130,028	65.00
66.00	06600	PHYSICAL THERAPY	0	1,974,442	66.00
66.01	06601	CARDIAC REHAB	0	455,108	66.01
69.00	06900	ELECTROCARDIOLOGY	0	238,158	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	82,150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,264,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,130,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,905,169	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	129,709	90.00
91.00	09100	EMERGENCY	0	3,227,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	2,002,508	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,312,075	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	566,957	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	42,161,826	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	13,970,587	192.01
192.02	19202	PHARMACARE	0	8,422,873	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	49,107	192.03
192.04	19204	BUSINESS HEALTH	0	304,598	192.04
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	194.01
194.02	07952	FOUNDATION	0	190,739	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	65,099,730	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT CLINIC	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	456,179	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	1,751,395	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,077	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	41,693	0	0	0	9.00
10.00	01000	DIETARY	0	21,884	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	67,530	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,151	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,497	0	0	0	14.00
15.00	01500	PHARMACY	0	25,291	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,349	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,582	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	256,100	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108,743	0	0	0	31.00
43.00	04300	NURSERY	0	19,482	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	387,469	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	301,309	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,443	0	0	0	54.00
60.00	06000	LABORATORY	0	91,489	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	23,850	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	113,919	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	59,952	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	168,083	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,931	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	6,552	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	6,552	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,237,502	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	111,407	0	0	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,348,909	0	0	0	202.00

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		Cost Center Description	CAPITAL RELATED COSTS					
			BUTLER	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	
			1.04	1.05	1.07	1.08	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	0	6,217	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	624	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	624	0	6,217	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	8,192	0	59,843	4,996	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	8,816	0	66,060	4,996	0	202.00

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		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	456,179	0	456,179			5.00
7.00	00700	OPERATION OF PLANT	1,757,612	0	34,944	1,792,556		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,077	0	518	14,282	40,877	8.00
9.00	00900	HOUSEKEEPING	41,693	0	12,401	23,743	1,699	9.00
10.00	01000	DIETARY	21,884	0	2,036	14,425	285	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	67,530	0	4,620	36,984	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,151	0	5,921	12,679	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,497	0	2,296	15,059	0	14.00
15.00	01500	PHARMACY	25,291	0	6,579	13,851	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,349	0	2,853	18,922	0	16.00
17.00	01700	SOCIAL SERVICE	3,582	0	822	1,962	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	256,100	0	25,447	140,255	8,273	30.00
31.00	03100	INTENSIVE CARE UNIT	108,743	0	13,826	59,554	3,543	31.00
43.00	04300	NURSERY	19,482	0	2,200	10,669	582	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	387,469	0	24,576	212,201	7,293	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	301,309	0	7,791	165,015	1,586	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,443	0	25,195	111,417	4,780	54.00
60.00	06000	LABORATORY	92,113	0	27,474	63,693	25	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	23,850	0	7,300	13,061	0	65.00
66.00	06600	PHYSICAL THERAPY	113,919	0	11,923	62,389	827	66.00
66.01	06601	CARDIAC REHAB	59,952	0	2,238	32,833	232	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	1,511	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	540	0	305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	12,678	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,920	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	27,279	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	854	0	322	90.00
91.00	09100	EMERGENCY	168,083	0	17,937	92,052	8,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,931	0	13,273	9,820	1,471	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	6,552	0	8,264	3,588	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,552	0	3,797	3,588	32	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,244,343	0	315,013	1,132,042	40,193	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	184,438	0	78,612	660,514	501	192.01
192.02	19202	PHARMACARE	0	0	58,757	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	344	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	2,131	0	183	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	1,322	0	0	194.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,428,781	0	456,179	1,792,556	40,877	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	NURSING ADMINISTRATION	
			9.00	10.00	10.01	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
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	79,536					9.00
10.00	01000	DIETARY	654	39,284				10.00
10.01	01001	SNACK BAR	0	0	0			10.01
11.00	01100	CAFETERIA	1,677	0	0	110,811		11.00
13.00	01300	NURSING ADMINISTRATION	575	0	0	2,227	44,553	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	683	0	0	965	1,008	14.00
15.00	01500	PHARMACY	628	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	858	0	0	2,367	0	16.00
17.00	01700	SOCIAL SERVICE	89	0	0	341	356	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,358	29,301	0	10,350	10,811	30.00
31.00	03100	INTENSIVE CARE UNIT	2,700	9,983	0	5,020	5,243	31.00
43.00	04300	NURSERY	484	0	0	846	884	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,619	0	0	8,488	8,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,480	0	0	2,213	2,311	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,051	0	0	9,917	0	54.00
60.00	06000	LABORATORY	2,887	0	0	7,949	686	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	592	0	0	3,434	0	65.00
66.00	06600	PHYSICAL THERAPY	2,828	0	0	1,882	0	66.00
66.01	06601	CARDIAC REHAB	1,488	0	0	1,026	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	757	790	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	242	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	2,159	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	215	225	90.00
91.00	09100	EMERGENCY	4,173	0	0	8,252	8,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	445	0	0	9,207	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	163	0	0	4,164	4,351	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	163	0	0	382	400	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,595	39,284	0	82,403	44,553	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	29,941	0	0	24,592	0	192.01
192.02	19202	PHARMACARE	0	0	0	3,523	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	293	0	194.02
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)	79,536	39,284	0	110,811	44,553	202.00

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		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
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
10.01	01001	SNACK BAR						10.01
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,508					14.00
15.00	01500	PHARMACY	0	46,349				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	53,349			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,152		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,984	7,152	497,031	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,472	0	210,084	31.00
43.00	04300	NURSERY	0	0	293	0	35,440	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	9,294	0	667,807	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	767	0	488,472	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,779	0	369,582	54.00
60.00	06000	LABORATORY	0	0	7,810	0	202,637	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	1,438	0	49,675	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,932	0	195,700	66.00
66.01	06601	CARDIAC REHAB	0	0	194	0	97,963	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	98	0	3,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	271	0	1,358	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	47,508	0	2,840	0	65,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46,349	2,175	0	75,803	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	91	0	1,707	90.00
91.00	09100	EMERGENCY	0	0	5,869	0	313,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	52,147	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	27,082	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	29	0	14,943	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,508	46,349	47,336	7,152	3,377,617	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	4,696	0	983,294	192.01
192.02	19202	PHARMACARE	0	0	1,317	0	63,597	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	344	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	2,314	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	1,615	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	47,508	46,349	53,349	7,152	4,428,781	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB WEST			1.01
1.02	00102	NORTH ANNEX			1.02
1.03	00103	GARRETT CLINIC			1.03
1.04	00104	BUTLER			1.04
1.05	00105	MOB EAST			1.05
1.07	00107	MEDICAL ARTS			1.07
1.08	00108	SMALTZ WAY			1.08
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
10.01	01001	SNACK BAR			10.01
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	497,031	30.00
31.00	03100	INTENSIVE CARE UNIT	0	210,084	31.00
43.00	04300	NURSERY	0	35,440	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	667,807	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	488,472	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	369,582	54.00
60.00	06000	LABORATORY	0	202,637	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	49,675	65.00
66.00	06600	PHYSICAL THERAPY	0	195,700	66.00
66.01	06601	CARDIAC REHAB	0	97,963	66.01
69.00	06900	ELECTROCARDIOLOGY	0	3,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,358	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	65,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75,803	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	1,707	90.00
91.00	09100	EMERGENCY	0	313,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	52,147	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	27,082	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	14,943	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,377,617	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	983,294	192.01
192.02	19202	PHARMACARE	0	63,597	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	344	192.03
192.04	19204	BUSINESS HEALTH	0	2,314	192.04
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	194.01
194.02	07952	FOUNDATION	0	1,615	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,428,781	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MOB WEST (SQUARE FEET)	NORTH ANNEX (SQUARE FEET)	GARRETT CLINIC (SQUARE FEET)	BUTLER (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	199,123					1.00
1.01	00101	MOB WEST	0	16,334				1.01
1.02	00102	NORTH ANNEX	0	0	1,824			1.02
1.03	00103	GARRETT CLINIC	0	0	0	3,750		1.03
1.04	00104	BUTLER	0	0	0	0	4,977	1.04
1.05	00105	MOB EAST	0	0	0	0	0	1.05
1.07	00107	MEDICAL ARTS	0	0	0	0	0	1.07
1.08	00108	SMALTZ WAY	0	0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,887	0	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	80,191	2,931	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,194	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,909	0	0	0	0	9.00
10.00	01000	DIETARY	1,002	0	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	3,092	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	0	0	14.00
15.00	01500	PHARMACY	1,158	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,298	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,726	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	0	0	0	0	31.00
43.00	04300	NURSERY	892	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,741	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,796	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	0	0	0	0	54.00
60.00	06000	LABORATORY	4,189	0	0	784	352	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,696	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	821	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	300	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	300	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,022	2,931	0	784	352	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	5,101	13,403	1,824	2,966	4,625	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	4,348,909	0	0	0	8,816	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.840315	0.000000	0.000000	0.000000	1.771348	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MOB WEST (SQUARE FEET)	NORTH ANNEX (SQUARE FEET)	GARRETT CLINIC (SQUARE FEET)	BUTLER (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB EAST (SQUARE FEET)	MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	
			1.05	1.07	1.08	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST	37,481					1.05
1.07	00107	MEDICAL ARTS	0	7,225				1.07
1.08	00108	SMALTZ WAY	0	0	3,168			1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP				199,123		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	28,385,255	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,019	0	0	20,887	4,129,630	5.00
7.00	00700	OPERATION OF PLANT	11,140	680	0	80,191	613,519	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,194	29,999	8.00
9.00	00900	HOUSEKEEPING	76	0	0	1,909	859,120	9.00
10.00	01000	DIETARY	204	0	0	1,002	110,850	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	3,092	355,353	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,060	505,591	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,259	102,560	14.00
15.00	01500	PHARMACY	0	0	0	1,158	591,122	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284	0	0	1,298	215,593	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	164	73,384	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	11,726	1,940,215	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	4,979	1,003,425	31.00
43.00	04300	NURSERY	0	0	0	892	177,282	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,741	1,686,601	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,796	463,291	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,315	1,769,774	54.00
60.00	06000	LABORATORY	0	0	0	4,189	1,189,354	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,092	611,602	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,216	297,908	66.00
66.01	06601	CARDIAC REHAB	0	0	0	2,745	165,152	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	139,662	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	35,396	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	54,019	90.00
91.00	09100	EMERGENCY	0	0	0	7,696	1,463,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	821	1,221,686	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	300	694,164	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	300	127,312	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,723	680	0	194,022	20,627,387	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	20,758	6,545	3,168	5,101	6,699,805	192.01
192.02	19202	PHARMACARE	0	0	0	0	816,038	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	31,855	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	143,726	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	66,444	194.02
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	66,060	4,996	0	7,029,538	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB EAST (SQUARE FEET)	MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	
			1.05	1.07	1.08	2.00	4.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	9.143253	1.577020	0.000000	0.247648	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,196,471	55,903,259				5.00
7.00	00700	OPERATION OF PLANT	0	4,282,410	149,866			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,505	1,194	148,942		8.00
9.00	00900	HOUSEKEEPING	0	1,519,775	1,985	6,192	146,687	9.00
10.00	01000	DIETARY	0	249,527	1,206	1,040	1,206	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	566,197	3,092	0	3,092	11.00
13.00	01300	NURSING ADMINISTRATION	0	725,581	1,060	0	1,060	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	281,362	1,259	0	1,259	14.00
15.00	01500	PHARMACY	0	806,227	1,158	0	1,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	349,576	1,582	0	1,582	16.00
17.00	01700	SOCIAL SERVICE	0	100,762	164	0	164	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,118,525	11,726	30,143	11,726	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,694,348	4,979	12,909	4,979	31.00
43.00	04300	NURSERY	0	269,556	892	2,119	892	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,011,788	17,741	26,573	17,741	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	954,825	13,796	5,778	13,796	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,087,644	9,315	17,418	9,315	54.00
60.00	06000	LABORATORY	0	3,366,897	5,325	90	5,325	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	894,604	1,092	0	1,092	65.00
66.00	06600	PHYSICAL THERAPY	0	1,461,152	5,216	3,012	5,216	66.00
66.01	06601	CARDIAC REHAB	0	274,323	2,745	845	2,745	66.01
69.00	06900	ELECTROCARDIOLOGY	0	185,171	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	66,143	0	1,111	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,553,673	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	970,613	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,343,035	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	104,606	0	1,175	0	90.00
91.00	09100	EMERGENCY	0	2,198,172	7,696	32,568	7,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,626,645	821	5,360	821	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,012,795	300	0	300	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	465,367	300	117	300	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,196,471	38,604,804	94,644	146,450	91,465	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	9,632,587	55,222	1,827	55,222	192.01
192.02	19202	PHARMACARE	0	7,200,593	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	42,170	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	261,132	0	665	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	161,973	0	0	0	194.02
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)		9,196,471	4,986,896	113,683	1,840,567	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.164507	33.275700	0.763270	12.547581	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		456,179	1,792,556	40,877	79,536	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet B-1 Date/Time Prepared: 2/25/2020 11:43 am

	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A	5.00	7.00	8.00	9.00	
205.00	Unit cost multiplier (Wkst. B, Part II)		0.008160	11.961059	0.274449	0.542216	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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			10.00	10.01	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB WEST						1.01
1.02	00102	NORTH ANNEX						1.02
1.03	00103	GARRETT CLINIC						1.03
1.04	00104	BUTLER						1.04
1.05	00105	MOB EAST						1.05
1.07	00107	MEDICAL ARTS						1.07
1.08	00108	SMALTZ WAY						1.08
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	28,324					10.00
10.01	01001	SNACK BAR	0	0				10.01
11.00	01100	CAFETERIA	0	0	32,495			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	653	260,148		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	283	5,886	100	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	694	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	100	2,080	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,126	0	3,035	63,121	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,198	0	1,472	30,617	0	31.00
43.00	04300	NURSERY	0	0	248	5,163	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,489	51,774	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	649	13,493	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,908	0	0	54.00
60.00	06000	LABORATORY	0	0	2,331	4,004	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	1,007	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	552	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	301	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	222	4,615	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	71	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	633	0	100	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	63	1,315	0	90.00
91.00	09100	EMERGENCY	0	0	2,420	50,341	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,700	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	1,221	25,403	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	112	2,336	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,324	0	24,164	260,148	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	7,212	0	0	192.01
192.02	19202	PHARMACARE	0	0	1,033	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	86	0	0	194.02
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)	346,632	0	801,025	909,613	412,896	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.238102	0.000000	24.650715	3.496521	4,128.960000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			10.00	10.01	11.00	13.00	14.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	39,284	0	110,811	44,553	47,508	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.386951	0.000000	3.410094	0.171260	475.080000	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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB WEST					1.01
1.02	00102	NORTH ANNEX					1.02
1.03	00103	GARRETT CLINIC					1.03
1.04	00104	BUTLER					1.04
1.05	00105	MOB EAST					1.05
1.07	00107	MEDICAL ARTS					1.07
1.08	00108	SMALTZ WAY					1.08
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
10.01	01001	SNACK BAR					10.01
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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	182,583,957			16.00
17.00	01700	SOCIAL SERVICE	0	0	100		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	10,217,727	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,041,350	0		31.00
43.00	04300	NURSERY	0	1,004,680	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	31,829,893	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,625,532	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,368,812	0		54.00
60.00	06000	LABORATORY	0	26,745,064	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	4,923,836	0		65.00
66.00	06600	PHYSICAL THERAPY	0	6,617,684	0		66.00
66.01	06601	CARDIAC REHAB	0	664,305	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	337,145	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	929,279	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,727,045	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	7,448,759	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	311,361	0		90.00
91.00	09100	EMERGENCY	0	20,099,362	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	98,795	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	161,990,629	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	16,083,142	0		192.01
192.02	19202	PHARMACARE	0	4,510,186	0		192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0		192.03
192.04	19204	BUSINESS HEALTH	0	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0		194.00
194.01	07951	ADULT DAY CARE	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0		194.02
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)	991,920	496,684	134,591		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9,919.200000	0.002720	1,345.910000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 11:43 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	46,349	53,349	7,152		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	463.490000	0.000292	71.520000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,908,318		4,908,318	7,719	4,916,037	30.00
31.00	03100	INTENSIVE CARE UNIT	2,456,228		2,456,228	7,719	2,463,947	31.00
43.00	04300	NURSERY	383,290		383,290	0	383,290	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,669,443		4,669,443	219,653	4,889,096	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,818,806		1,818,806	0	1,818,806	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,198,224		4,198,224	0	4,198,224	54.00
60.00	06000	LABORATORY	4,309,061		4,309,061	0	4,309,061	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,130,028	0	1,130,028	0	1,130,028	65.00
66.00	06600	PHYSICAL THERAPY	1,974,442	0	1,974,442	0	1,974,442	66.00
66.01	06601	CARDIAC REHAB	455,108	0	455,108	0	455,108	66.01
69.00	06900	ELECTROCARDIOLOGY	238,158		238,158	0	238,158	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	82,150		82,150	0	82,150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,264,221		2,264,221	0	2,264,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,130,286		1,130,286	0	1,130,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,905,169		4,905,169	0	4,905,169	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	129,709		129,709	0	129,709	90.00
91.00	09100	EMERGENCY	3,227,645		3,227,645	0	3,227,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,052,285		2,052,285		2,052,285	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,002,508		2,002,508	0	2,002,508	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,312,075		1,312,075		1,312,075	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	566,957		566,957		566,957	116.00
200.00		Subtotal (see instructions)	44,214,111	0	44,214,111	235,091	44,449,202	200.00
201.00		Less Observation Beds	2,052,285		2,052,285		2,052,285	201.00
202.00		Total (see instructions)	42,161,826	0	42,161,826	235,091	42,396,917	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	10,128,160		10,128,160			30.00
31.00	03100	INTENSIVE CARE UNIT	5,003,850		5,003,850			31.00
43.00	04300	NURSERY	1,006,387		1,006,387			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,379,976	24,003,008	31,382,984	0.148789	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,496,761	111,544	2,608,305	0.697313	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,600,932	29,257,048	32,857,980	0.127769	0.000000	54.00
60.00	06000	LABORATORY	3,862,866	22,482,901	26,345,767	0.163558	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,259,740	1,617,028	4,876,768	0.231717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	674,373	5,841,590	6,515,963	0.303016	0.000000	66.00
66.01	06601	CARDIAC REHAB	9,513	643,977	653,490	0.696427	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	45,213	287,432	332,645	0.715952	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,000	913,012	914,012	0.089878	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,261,266	3,552,618	4,813,884	0.470352	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,543,782	2,279,210	4,822,992	0.234354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,346,628	5,993,732	7,340,360	0.668246	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,532	304,720	306,252	0.423537	0.000000	90.00
91.00	09100	EMERGENCY	2,304,828	17,488,249	19,793,077	0.163069	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	15,000	3,977,851	3,992,851	0.513990	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	247	7,042,139	7,042,386	0.284351	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,543,216	1,543,216			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	98,795	0	98,795			116.00
200.00		Subtotal (see instructions)	45,040,849	127,339,275	172,380,124			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,040,849	127,339,275	172,380,124			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.155788	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.697313	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127769	54.00
60.00	06000	LABORATORY	0.163558	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.231717	65.00
66.00	06600	PHYSICAL THERAPY	0.303016	66.00
66.01	06601	CARDIAC REHAB	0.696427	66.01
69.00	06900	ELECTROCARDIOLOGY	0.715952	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089878	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.470352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.668246	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.423537	90.00
91.00	09100	EMERGENCY	0.163069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.513990	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.284351	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I | Date/Time Prepared: 2/25/2020 11:43 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,908,318		4,908,318	7,719	4,916,037	30.00
31.00	03100	INTENSIVE CARE UNIT	2,456,228		2,456,228	7,719	2,463,947	31.00
43.00	04300	NURSERY	383,290		383,290	0	383,290	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,669,443		4,669,443	219,653	4,889,096	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,818,806		1,818,806	0	1,818,806	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,198,224		4,198,224	0	4,198,224	54.00
60.00	06000	LABORATORY	4,309,061		4,309,061	0	4,309,061	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,130,028	0	1,130,028	0	1,130,028	65.00
66.00	06600	PHYSICAL THERAPY	1,974,442	0	1,974,442	0	1,974,442	66.00
66.01	06601	CARDIAC REHAB	455,108	0	455,108	0	455,108	66.01
69.00	06900	ELECTROCARDIOLOGY	238,158		238,158	0	238,158	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	82,150		82,150	0	82,150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,264,221		2,264,221	0	2,264,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,130,286		1,130,286	0	1,130,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,905,169		4,905,169	0	4,905,169	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	129,709		129,709	0	129,709	90.00
91.00	09100	EMERGENCY	3,227,645		3,227,645	0	3,227,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,052,285		2,052,285		2,052,285	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,002,508		2,002,508	0	2,002,508	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,312,075		1,312,075		1,312,075	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	566,957		566,957		566,957	116.00
200.00		Subtotal (see instructions)	44,214,111	0	44,214,111	235,091	44,449,202	200.00
201.00		Less Observation Beds	2,052,285		2,052,285		2,052,285	201.00
202.00		Total (see instructions)	42,161,826	0	42,161,826	235,091	42,396,917	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I | Date/Time Prepared: 2/25/2020 11:43 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	10,128,160		10,128,160			30.00
31.00	03100	INTENSIVE CARE UNIT	5,003,850		5,003,850			31.00
43.00	04300	NURSERY	1,006,387		1,006,387			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,379,976	24,003,008	31,382,984	0.148789	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,496,761	111,544	2,608,305	0.697313	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,600,932	29,257,048	32,857,980	0.127769	0.000000	54.00
60.00	06000	LABORATORY	3,862,866	22,482,901	26,345,767	0.163558	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,259,740	1,617,028	4,876,768	0.231717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	674,373	5,841,590	6,515,963	0.303016	0.000000	66.00
66.01	06601	CARDIAC REHAB	9,513	643,977	653,490	0.696427	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	45,213	287,432	332,645	0.715952	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,000	913,012	914,012	0.089878	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,261,266	3,552,618	4,813,884	0.470352	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,543,782	2,279,210	4,822,992	0.234354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,346,628	5,993,732	7,340,360	0.668246	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,532	304,720	306,252	0.423537	0.000000	90.00
91.00	09100	EMERGENCY	2,304,828	17,488,249	19,793,077	0.163069	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	15,000	3,977,851	3,992,851	0.513990	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	247	7,042,139	7,042,386	0.284351	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,543,216	1,543,216			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	98,795	0	98,795			116.00
200.00		Subtotal (see instructions)	45,040,849	127,339,275	172,380,124			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,040,849	127,339,275	172,380,124			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 11:43 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	CARDIAC REHAB	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part I Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	497,031	0	497,031	5,531	89.86	30.00
31.00	INTENSIVE CARE UNIT	210,084		210,084	1,122	187.24	31.00
43.00	NURSERY	35,440		35,440	673	52.66	43.00
200.00	Total (lines 30 through 199)	742,555		742,555	7,326		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,106	99,385	30.00
31.00	INTENSIVE CARE UNIT	282	52,802	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	1,388	152,187	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		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	667,807	31,382,984	0.021279	1,729,448	36,801	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	488,472	2,608,305	0.187276	377	71	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	369,582	32,857,980	0.011248	1,700,121	19,123	54.00
60.00	06000	LABORATORY	202,637	26,345,767	0.007691	1,326,378	10,201	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	49,675	4,876,768	0.010186	880,799	8,972	65.00
66.00	06600	PHYSICAL THERAPY	195,700	6,515,963	0.030034	283,198	8,506	66.00
66.01	06601	CARDIAC REHAB	97,963	653,490	0.149907	2,892	434	66.01
69.00	06900	ELECTROCARDIOLOGY	3,156	332,645	0.009488	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,358	914,012	0.001486	674	1	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	65,185	4,813,884	0.013541	589,319	7,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,920	4,822,992	0.001642	704,290	1,156	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,803	7,340,360	0.010327	414,877	4,284	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,707	306,252	0.005574	967	5	90.00
91.00	09100	EMERGENCY	313,925	19,793,077	0.015860	1,039,145	16,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	207,494	3,992,851	0.051966	14,344	745	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,748,384	147,557,330		8,686,829	114,760	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part III | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	5,531	0.00	1,106	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,122	0.00	282	31.00
43.00	04300	NURSERY		0	673	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	7,326		1,388	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0045

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

Worksheet D Part IV

Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		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	31,382,984	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,608,305	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,857,980	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,345,767	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,876,768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,515,963	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	0	0	653,490	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	332,645	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	914,012	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	4,813,884	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,822,992	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,340,360	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	306,252	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	19,793,077	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	3,992,851	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	147,557,330		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0045

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

Worksheet D Part IV

Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		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	1,729,448	0	5,286,226	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	377	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,700,121	0	5,749,386	0	54.00
60.00	06000	LABORATORY	0.000000	1,326,378	0	1,856,916	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	880,799	0	179,537	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	283,198	0	37,908	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	2,892	0	222,470	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	114,015	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	674	0	205,428	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	589,319	0	560,875	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	704,290	0	573,997	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	414,877	0	2,069,706	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	967	0	74,815	0	90.00
91.00	09100	EMERGENCY	0.000000	1,039,145	0	2,572,483	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	14,344	0	544,908	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		8,686,829	0	20,048,670	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.148789	5,286,226	0	0	786,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.697313	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127769	5,749,386	0	0	734,593	54.00
60.00	06000	LABORATORY	0.163558	1,856,916	0	0	303,713	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.231717	179,537	0	0	41,602	65.00
66.00	06600	PHYSICAL THERAPY	0.303016	37,908	0	0	11,487	66.00
66.01	06601	CARDIAC REHAB	0.696427	222,470	0	0	154,934	66.01
69.00	06900	ELECTROCARDIOLOGY	0.715952	114,015	0	0	81,629	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089878	205,428	0	0	18,463	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.470352	560,875	0	0	263,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234354	573,997	0	0	134,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.668246	2,069,706	0	9,226	1,383,073	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.423537	74,815	0	0	31,687	90.00
91.00	09100	EMERGENCY	0.163069	2,572,483	0	0	419,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.513990	544,908	0	0	280,077	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.284351		0			95.00
200.00		Subtotal (see instructions)		20,048,670	0	9,226	4,645,609	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		20,048,670	0	9,226	4,645,609	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,165	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	6,165	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,165	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,531	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,531	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,222	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,106	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,916,037	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,916,037	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,916,037	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)	888.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	983,035	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)	983,035	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

	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	2,463,947	1,122	2,196.03	282	619,280	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)	1,892,553	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,494,868	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)	152,187	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	114,760	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	266,947	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,227,921	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	2,309	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	888.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,052,285	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

	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	497,031	4,916,037	0.101104	2,052,285	207,494	90.00
91.00	Nursing School cost	0	4,916,037	0.000000	2,052,285	0	91.00
92.00	Allied health cost	0	4,916,037	0.000000	2,052,285	0	92.00
93.00	All other Medical Education	0	4,916,037	0.000000	2,052,285	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 11:43 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,531	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,531	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,222	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	158	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	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)	673	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,908,318	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,908,318	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,908,318	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)	887.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	140,212	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)	140,212	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 11:43 am

Title XIX | 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)	383,290	673	569.52	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,456,228	1,122	2,189.15	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	98,669	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	238,881	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	2,309	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	887.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,049,053	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 11:43 am

Title XIX | 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	497,031	4,908,318	0.101263	2,049,053	207,493	90.00
91.00	Nursing School cost	0	4,908,318	0.000000	2,049,053	0	91.00
92.00	Allied health cost	0	4,908,318	0.000000	2,049,053	0	92.00
93.00	All other Medical Education	0	4,908,318	0.000000	2,049,053	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

		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		2,826,167		30.00
31.00	03100	INTENSIVE CARE UNIT		1,118,077		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.155788	1,729,448	269,427	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.697313	377	263	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127769	1,700,121	217,223	54.00
60.00	06000	LABORATORY	0.163558	1,326,378	216,940	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.231717	880,799	204,096	65.00
66.00	06600	PHYSICAL THERAPY	0.303016	283,198	85,814	66.00
66.01	06601	CARDIAC REHAB	0.696427	2,892	2,014	66.01
69.00	06900	ELECTROCARDIOLOGY	0.715952	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089878	674	61	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.470352	589,319	277,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234354	704,290	165,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.668246	414,877	277,240	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.423537	967	410	90.00
91.00	09100	EMERGENCY	0.163069	1,039,145	169,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.513990	14,344	7,373	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,686,829	1,892,553	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)		8,686,829		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/25/2020 11:43 am
	Title XIX	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		449,182		30.00
31.00	03100	INTENSIVE CARE UNIT		96,545		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.148789	57,988	8,628	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.697313	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127769	26,975	3,447	54.00
60.00	06000	LABORATORY	0.163558	120,287	19,674	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.231717	63,757	14,774	65.00
66.00	06600	PHYSICAL THERAPY	0.303016	5,711	1,731	66.00
66.01	06601	CARDIAC REHAB	0.696427	180	125	66.01
69.00	06900	ELECTROCARDIOLOGY	0.715952	3,597	2,575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089878	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.470352	12,249	5,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234354	32,664	7,655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.668246	40,921	27,345	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.423537	0	0	90.00
91.00	09100	EMERGENCY	0.163069	42,646	6,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.513990	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		406,975	98,669	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)		406,975		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,663,975	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	4,324	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	30.67	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.10	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.12	31.00
32.00	Sum of lines 30 and 31	26.22	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.85	33.00
34.00	Disproportionate share adjustment (see instructions)	72,260	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000059248	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	490,151	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	490,151	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	490,151		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,230,710		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,230,710	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	214,123	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	3,444,833	59.00
60.00	Primary payer payments	3,958	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,440,875	61.00
62.00	Deductibles billed to program beneficiaries	479,188	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	8,453	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	5,494	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,453	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,967,181	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	5,443	70.93
70.94	HRR adjustment amount (see instructions)	-66,067	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	484,102	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,390,659	71.00
71.01	Sequestration adjustment (see instructions)		67,813	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		3,124,433	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		198,413	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		72,849	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,663,975	0		2,663,975	2,663,975	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,324	0		4,324	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1085	0.1085	0.1085	0.1085		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	72,260	0	0	72,260	72,260	11.00
11.01	Uncompensated care payments	36.00	490,151	0	0	490,151	490,151	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,230,710	0	0	3,230,710	3,230,710	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,230,710	0	0	3,230,710	3,230,710	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/25/2020 11:43 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	214,123	0	0	214,123	214,123	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	3,444,833	3,444,833	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	213,789	0	0	213,789	213,789	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	334	0	0	334	334	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	214,123	0	0	214,123	214,123	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.140530		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				484,102	484,102	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/25/2020 11:43 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,663,975		2,663,975	2,663,975	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	4,324		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,324		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1085	0.1085	0.1085		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	72,260	0	72,260	72,260	11.00
11.01	Uncompensated care payments	36.00	490,151	0	490,151	490,151	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,230,710	4,324	3,226,386	3,230,710	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,230,710	4,324	3,226,386	3,230,710	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	214,123	0	214,123	214,123	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,324	3,440,509	3,444,833	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/25/2020 11:43 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	213,789	0	213,789	213,789	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	334	0	334	334	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	214,123	0	214,123	214,123	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	484,102		484,102	484,102	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	5,443	0	5,443	5,443	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-66,067	0	-66,067	-66,067	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part B | Date/Time Prepared: 2/25/2020 11:43 am

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,165	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,645,609	2.00
3.00	OPPS payments	3,770,621	3.00
4.00	Outlier payment (see instructions)	16,644	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)	6,165	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	9,226	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)	9,226	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)	9,226	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,061	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)	6,165	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)	3,787,265	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	758,998	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,034,432	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,034,432	30.00
31.00	Primary payer payments	7,116	31.00
32.00	Subtotal (line 30 minus line 31)	3,027,316	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)	86,983	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	56,539	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,983	36.00
37.00	Subtotal (see instructions)	3,083,855	37.00
38.00	MSP-LCC reconciliation amount from PS&R	49	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)	3,083,806	40.00
40.01	Sequestration adjustment (see instructions)	61,676	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,965,518	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	56,612	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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2020 11:43 am

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		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		3,124,433		2,965,518	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,124,433		2,965,518	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		198,413		56,612	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,322,846		3,022,130	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: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

		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 | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-3 Part VII Date/Time Prepared: 2/25/2020 11:43 am

	Title XIX	Hospital	Cost	
		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	238,881		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	238,881	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	238,881	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	545,727		8.00
9.00	Ancillary service charges	406,975	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	952,702	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	952,702	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	713,821	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	238,881	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	238,881	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	238,881	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	238,881	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	238,881	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	238,881	0	40.00
41.00	Interim payments	520,692	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-281,811	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G | Date/Time Prepared: 2/25/2020 11:43 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	838,052	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,356,507	0	0	0	4.00
5.00	Other receivable	79,373	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,562,779	0	0	0	6.00
7.00	Inventory	1,642,647	0	0	0	7.00
8.00	Prepaid expenses	504,683	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,858,483	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	347,792	0	0	0	12.00
13.00	Land improvements	1,857,914	0	0	0	13.00
14.00	Accumulated depreciation	-1,852,386	0	0	0	14.00
15.00	Buildings	61,359,416	0	0	0	15.00
16.00	Accumulated depreciation	-36,098,138	0	0	0	16.00
17.00	Leasehold improvements	2,735,818	0	0	0	17.00
18.00	Accumulated depreciation	-50,677	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	26,001,251	0	0	0	23.00
24.00	Accumulated depreciation	-22,131,936	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,169,054	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	18,802,730	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	28,141	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,830,871	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	62,858,408	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,125,310	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,063,587	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	615,148	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	165,944	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,969,989	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,630,611	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,630,611	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,600,600	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	46,257,808				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)	46,257,808	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	62,858,408	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-1 | Date/Time Prepared: 2/25/2020 11:43 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		46,634,753		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-376,945				2.00
3.00	Total (sum of line 1 and line 2)		46,257,808		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)		46,257,808		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)		46,257,808		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: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2020 11:43 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,134,547		11,134,547	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,134,547		11,134,547	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,003,850		5,003,850	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)	5,003,850		5,003,850	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,138,397		16,138,397	17.00
18.00	Ancillary services	21,329,374	85,158,540	106,487,914	18.00
19.00	Outpatient services	7,457,036	33,612,381	41,069,417	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		1,543,216	1,543,216	22.00
23.00	AMBULANCE SERVICES	-1,753	7,044,139	7,042,386	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	170,350	-71,555	98,795	26.00
27.00	DEKALB MEDICAL SERVICES	0	16,083,142	16,083,142	27.00
27.01	OTHER INCOME	0	13,401	13,401	27.01
27.02	SELF INSURANCE	0	2,286,303	2,286,303	27.02
27.03	PHARMACARE	0	6,324,033	6,324,033	27.03
27.04	OTHER INCOME	70,936	47,601	118,537	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	45,164,340	152,041,201	197,205,541	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		71,909,451		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)		71,909,451		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-3 | Date/Time Prepared: 2/25/2020 11:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	197,205,541	1.00
2.00	Less contractual allowances and discounts on patients' accounts	128,769,623	2.00
3.00	Net patient revenues (line 1 minus line 2)	68,435,918	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	71,909,451	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,473,533	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	2,884,780	24.00
24.01	INVESTMENT RETURN	597,285	24.01
24.02	LOSS ON DISPOSAL	-41,471	24.02
24.03	CONTRIBUTION TO THE COMMUNITY	-549,116	24.03
24.04	EXCESS OF ASSETS ACQUIRED OVER LIABI	205,110	24.04
25.00	Total other income (sum of lines 6-24)	3,096,588	25.00
26.00	Total (line 5 plus line 25)	-376,945	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-376,945	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H | Date/Time Prepared: 2/25/2020 11:43 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	153,423	50,732	28,290	57,264	4,057	293,766	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	297,946	0	0	0	0	297,946	6.00
7.00	Physical Therapy	123,558	0	0	0	0	123,558	7.00
8.00	Occupational Therapy	36,206	0	0	0	0	36,206	8.00
9.00	Speech Pathology	2,719	0	0	0	0	2,719	9.00
10.00	Medical Social Services	29,136	0	0	0	0	29,136	10.00
11.00	Home Health Aide	51,176	0	0	0	0	51,176	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	694,164	50,732	28,290	57,264	4,057	834,507	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	0	293,766	-172	293,594	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	297,946	0	297,946	6.00
7.00	Physical Therapy	0	123,558	0	123,558	7.00
8.00	Occupational Therapy	0	36,206	0	36,206	8.00
9.00	Speech Pathology	0	2,719	0	2,719	9.00
10.00	Medical Social Services	0	29,136	0	29,136	10.00
11.00	Home Health Aide	0	51,176	0	51,176	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	834,507	-172	834,335	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-1 Part I | Date/Time Prepared: 2/25/2020 11:43 am

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	293,594	0	0	0	0	293,594	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	297,946	0	0	0	0	297,946	6.00
7.00	Physical Therapy	123,558	0	0	0	0	123,558	7.00
8.00	Occupational Therapy	36,206	0	0	0	0	36,206	8.00
9.00	Speech Pathology	2,719	0	0	0	0	2,719	9.00
10.00	Medical Social Services	29,136	0	0	0	0	29,136	10.00
11.00	Home Health Aide	51,176	0	0	0	0	51,176	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	834,335	0	0	0	0	834,335	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	293,594		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	161,769	459,715	6.00
7.00	Physical Therapy	67,086	190,644	7.00
8.00	Occupational Therapy	19,658	55,864	8.00
9.00	Speech Pathology	1,476	4,195	9.00
10.00	Medical Social Services	15,819	44,955	10.00
11.00	Home Health Aide	27,786	78,962	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		834,335	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-1 Part II | Date/Time Prepared: 2/25/2020 11:43 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-293,594	540,741	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	297,946	6.00
7.00	Physical Therapy	0	0	0	0	0	123,558	7.00
8.00	Occupational Therapy	0	0	0	0	0	36,206	8.00
9.00	Speech Pathology	0	0	0	0	0	2,719	9.00
10.00	Medical Social Services	0	0	0	0	0	29,136	10.00
11.00	Home Health Aide	0	0	0	0	0	51,176	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-293,594	540,741	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		293,594	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.542948	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part I
HHA CCN: 15-7157 | Date/Time Prepared: 2/25/2020 11:43 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT CLINIC	BUTLER	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	6,552	0	0	0	0	1.00
2.00	Skilled Nursing Care	459,715	0	0	0	0	0	2.00
3.00	Physical Therapy	190,644	0	0	0	0	0	3.00
4.00	Occupational Therapy	55,864	0	0	0	0	0	4.00
5.00	Speech Pathology	4,195	0	0	0	0	0	5.00
6.00	Medical Social Services	44,955	0	0	0	0	0	6.00
7.00	Home Health Aide	78,962	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	834,335	6,552	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CAPITAL RELATED COSTS MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		1.05	1.07	1.08	2.00	4.00	4A	
1.00	Administrative and General	0	0	0	0	171,908	178,460	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	459,715	2.00
3.00	Physical Therapy	0	0	0	0	0	190,644	3.00
4.00	Occupational Therapy	0	0	0	0	0	55,864	4.00
5.00	Speech Pathology	0	0	0	0	0	4,195	5.00
6.00	Medical Social Services	0	0	0	0	0	44,955	6.00
7.00	Home Health Aide	0	0	0	0	0	78,962	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	171,908	1,012,795	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2020 11:43 am

Home Health Agency I | PPS

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	
		5.00	7.00	8.00	9.00	10.00	10.01	
1.00	Administrative and General	29,358	9,983	0	3,764	0	0	1.00
2.00	Skilled Nursing Care	75,627	0	0	0	0	0	2.00
3.00	Physical Therapy	31,362	0	0	0	0	0	3.00
4.00	Occupational Therapy	9,190	0	0	0	0	0	4.00
5.00	Speech Pathology	690	0	0	0	0	0	5.00
6.00	Medical Social Services	7,395	0	0	0	0	0	6.00
7.00	Home Health Aide	12,990	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	166,612	9,983	0	3,764	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	30,099	88,822	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	30,099	88,822	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2020 11:43 am

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	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	340,486	0	340,486				1.00
2.00	Skilled Nursing Care	535,342	0	535,342	187,606	722,948		2.00
3.00	Physical Therapy	222,006	0	222,006	77,800	299,806		3.00
4.00	Occupational Therapy	65,054	0	65,054	22,798	87,852		4.00
5.00	Speech Pathology	4,885	0	4,885	1,712	6,597		5.00
6.00	Medical Social Services	52,350	0	52,350	18,346	70,696		6.00
7.00	Home Health Aide	91,952	0	91,952	32,224	124,176		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,312,075	0	1,312,075	340,486	1,312,075		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.350442			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0045 | HHA CCN: 15-7157

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

Worksheet H-2 Part II | Date/Time Prepared: 2/25/2020 11:43 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MOB WEST (SQUARE FEET)	NORTH ANNEX (SQUARE FEET)	GARRETT CLINIC (SQUARE FEET)	BUTLER (SQUARE FEET)	MOB EAST (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	300	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	300	0	0	0	0	0	20.00
21.00	Total cost to be allocated	6,552	0	0	0	0	0	21.00
22.00	Unit cost multiplier	21.840000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	CAPITAL RELATED COSTS MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.07	1.08	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	300	694,164	0	178,460	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	459,715	2.00
3.00	Physical Therapy	0	0	0	0	0	190,644	3.00
4.00	Occupational Therapy	0	0	0	0	0	55,864	4.00
5.00	Speech Pathology	0	0	0	0	0	4,195	5.00
6.00	Medical Social Services	0	0	0	0	0	44,955	6.00
7.00	Home Health Aide	0	0	0	0	0	78,962	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	300	694,164		1,012,795	20.00
21.00	Total cost to be allocated	0	0	0	171,908		166,612	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.247648		0.164507	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part II | Date/Time Prepared: 2/25/2020 11:43 am

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	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	10.01	11.00	
1.00	Administrative and General	300	0	300	0	0	1,221	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	300	0	300	0	0	1,221	20.00
21.00	Total cost to be allocated	9,983	0	3,764	0	0	30,099	21.00
22.00	Unit cost multiplier	33.276667	0.000000	12.546667	0.000000	0.000000	24.651106	22.00

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
		13.00	14.00	15.00	16.00	17.00		
1.00	Administrative and General	25,403	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	25,403	0	0	0	0		20.00
21.00	Total cost to be allocated	88,822	0	0	0	0		21.00
22.00	Unit cost multiplier	3.496516	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2020 11:43 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	722,948		722,948	3,201	225.85	1.00
2.00	Physical Therapy	3.00	299,806	0	299,806	1,264	237.19	2.00
3.00	Occupational Therapy	4.00	87,852	0	87,852	506	173.62	3.00
4.00	Speech Pathology	5.00	6,597	0	6,597	38	173.61	4.00
5.00	Medical Social Services	6.00	70,696		70,696	95	744.17	5.00
6.00	Home Health Aide	7.00	124,176		124,176	1,299	95.59	6.00
7.00	Total (sum of lines 1-6)		1,312,075	0	1,312,075	6,403		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		34620	0	22			8.00
8.01	Skilled Nursing Care		99915	0	1,107			8.01
9.00	Physical Therapy		34620	0	11			9.00
9.01	Physical Therapy		99915	0	420			9.01
10.00	Occupational Therapy		34620	0	10			10.00
10.01	Occupational Therapy		99915	0	167			10.01
11.00	Speech Pathology		34620	0	0			11.00
11.01	Speech Pathology		99915	0	12			11.01
12.00	Medical Social Services		34620	0	1			12.00
12.01	Medical Social Services		99915	0	39			12.01
13.00	Home Health Aide		34620	0	15			13.00
13.01	Home Health Aide		99915	0	405			13.01
14.00	Total (sum of lines 8-13)			0	2,209			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,129		0	254,985		1.00
2.00	Physical Therapy	0	431		0	102,229		2.00
3.00	Occupational Therapy	0	177		0	30,731		3.00
4.00	Speech Pathology	0	12		0	2,083		4.00
5.00	Medical Social Services	0	40		0	29,767		5.00
6.00	Home Health Aide	0	420		0	40,148		6.00
7.00	Total (sum of lines 1-6)	0	2,209		0	459,943		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2020 11:43 am

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	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	15,937	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	254,985	1.00
2.00	Physical Therapy	102,229	2.00
3.00	Occupational Therapy	30,731	3.00
4.00	Speech Pathology	2,083	4.00
5.00	Medical Social Services	29,767	5.00
6.00	Home Health Aide	40,148	6.00
7.00	Total (sum of lines 1-6)	459,943	7.00

	Cost Center Description	12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157

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

Worksheet H-3 Part II

Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.303016	0	0	col. 2, line 2.00		1.00
1.01	Physical Therapy 1	66.01	0.696427	0	0	col. 2, line 2.01		1.01
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.470352	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.668246	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/25/2020 11:43 am

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		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	244,583	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	56,519	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,589	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,493	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	7,042	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	159	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	316,385	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	316,385	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	316,385	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	316,385	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	316,385	31.00
31.01	Sequestration adjustment (see instructions)	0	6,328	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	310,057	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-5 | Date/Time Prepared: 2/25/2020 11:43 am

Home Health Agency I | PPS

		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		0		310,057	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		310,057	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		310,057	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	9,340	9,340	0	9,340	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	278,853	278,853	0	278,853	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	11,879	11,879	0	11,879	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	93,094	0	93,094	0	93,094	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	13,558	0	13,558	0	13,558	33.00
34.00	SPIRITUAL COUNSELING**	20,660	0	20,660	0	20,660	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	127,312	300,072	427,384	0	427,384	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O | Date/Time Prepared: 2/25/2020 11:43 am

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		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	9,340	3.00
4.00	ADMINISTRATIVE & GENERAL*	-98	278,755	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	11,879	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	93,094	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	13,558	33.00
34.00	SPIRITUAL COUNSELING**	0	20,660	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-98	427,286	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-2 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	91,597	0	91,597	0	91,597	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	20,327	0	20,327	0	20,327	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	111,924	0	111,924	0	111,924	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	91,597	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	20,327	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	111,924	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-3 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,079	0	1,079	0	1,079	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	240	0	240	0	240	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,319	0	1,319	0	1,319	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,079	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	240	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,319	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-4 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	418	0	418	0	418	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	13,558	0	13,558	0	13,558	33.00
34.00	SPIRITUAL COUNSELING	93	0	93	0	93	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	14,069	0	14,069	0	14,069	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	418	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	13,558	33.00
34.00	SPIRITUAL COUNSELING	0	93	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	14,069	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-5 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	6,552	6,552	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	9,340	31,529	40,869	3.00
4.00	ADMINISTRATIVE & GENERAL	278,755	79,317	358,072	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	9,983	9,983	5.00
6.00	LAUNDRY & LINEN SERVICE	0	89	89	6.00
7.00	HOUSEKEEPING	0	3,764	3,764	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	8,168	8,168	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	269	269	11.00
12.00	STAFF TRANSPORTATION	11,879		11,879	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	111,924		111,924	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,319		1,319	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14,069		14,069	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	427,286	139,671	566,957	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559

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

Worksheet O-6 Part I | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,552	6,552				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	40,869	0	0	40,869		3.00
4.00	ADMINISTRATIVE & GENERAL	358,072	0	0	0	358,072	4.00
5.00	PLANT OPERATION & MAINTENANCE	9,983	0	0	0	9,983	5.00
6.00	LAUNDRY & LINEN SERVICE	89	0	0	0	89	6.00
7.00	HOUSEKEEPING	3,764	0	0	0	3,764	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	8,168	0	0	0	8,168	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	269	0	0	0	269	11.00
12.00	STAFF TRANSPORTATION	11,879	0	0	0	11,879	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	111,924			40,212	152,136	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,319	4,717	0	474	6,510	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14,069	1,835	0	183	16,087	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	566,957	6,552	0	40,869	566,957	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part I | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	358,072					4.00
5.00	PLANT OPERATION & MAINTENANCE	17,113	27,096				5.00
6.00	LAUNDRY & LINEN SERVICE	153	0	242			6.00
7.00	HOUSEKEEPING	6,452	0		10,216		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	14,002	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	461	0		0		11.00
12.00	STAFF TRANSPORTATION	20,363	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	260,793					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	11,159	19,509	174	7,356	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	27,576	7,587	68	2,860	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	358,072	27,096	242	10,216	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part I | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	22,170					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		730			11.00
12.00	STAFF TRANSPORTATION	0			32,242		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	21,814	0	719	32,242	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	257	0	8	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	99	0	3	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	22,170	0	730	32,242	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part I | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		467,704	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	44,973	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	54,280	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	566,957	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part II

Hospice CCN: 15-1559 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	300					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	127,312			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-358,072	208,885	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	9,983	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	89	6.00
7.00	HOUSEKEEPING	0	0	0	0	3,764	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	8,168	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	269	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	11,879	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			125,265	0	152,136	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	216	0	1,476	0	6,510	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	84	0	571	0	16,087	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	6,552	0	40,869		358,072	100.00
101.00	UNIT COST MULTIPLIER	21.840000	0.000000	0.321015		1.714206	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part II | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	300					5.00
6.00	LAUNDRY & LINEN SERVICE	0	43				6.00
7.00	HOUSEKEEPING	0		300			7.00
8.00	DIETARY	0		0	43		8.00
9.00	NURSING ADMINISTRATION	0		0		22,988	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					22,618	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	216	31	216	31	267	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	84	12	84	12	103	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	27,096	242	10,216	0	22,170	100.00
101.00	UNIT COST MULTIPLIER	90.320000	5.627907	34.053333	0.000000	0.964416	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part II | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		2,674				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	2,631	100	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	31	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	12	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	730	32,242	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.272999	322.420000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0045 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part II
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Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-7 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.303016	0	0	0	1.00
1.01	CARDIAC REHAB	66.01	0.696427	0	0	0	1.01
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.668246	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.163558	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0.470352	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
1.01	CARDIAC REHAB	0	0	0	0	0	1.01
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-8 | Date/Time Prepared: 2/25/2020 11:43 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			467,704	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,631	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			177.77	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2,607	0		9.00
10.00	Program cost (line 8 times line 9)	463,446	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			44,973	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			31	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,450.74	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	31	0		14.00
15.00	Program cost (line 13 times line 14)	44,973	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			54,280	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			12	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			4,523.33	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	10	0		19.00
20.00	Program cost (line 18 times line 19)	45,233	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			566,957	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,674	22.00
23.00	Average cost per diem (line 21 divided by line 22)			212.03	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/25/2020 11:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	213,789	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	334	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	12.14	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	214,123	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00