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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 12:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 12:24 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEKIN MEMORIAL HOSPITAL (14-0120) for the cost reporting period beginning 05/01/2017 and ending 12/31/2017 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	130,961	-7,479	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	130,961	-7,479	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 SOUTH 13TH STREET	PO Box:			1.00
2.00	City: PEKIN	State: IL	Zip Code: 61554	County: TAZEWELL	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	PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	PEKIN HOME HEALTH	147057	37900		01/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	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)	Y	Y	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	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	304	721	0	0	238	57	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:22 pm

		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.	1		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.	1		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)	N		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) or (ii)? 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) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:22 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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

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		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:	438,335	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

		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)	Y	14H076	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: PROGRESSIVE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC	Contractor's Number: 00131	141.00
142.00	Street: 600 SOUTH 13TH STREET	PO Box:		142.00
143.00	City: PEKIN	State: IL	Zip Code: 61554	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:22 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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)	N		N		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)	Y	05/07/2018	Y	05/07/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 12:22 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	99	24,255	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)		99	24,255	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	1,960	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)		107	26,215	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	44.00	0	0		0	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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,735	114	5,489			1.00
2.00	HMO and other (see instructions)	1,271	808				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)	2,735	114	5,489			7.00
8.00	INTENSIVE CARE UNIT	209	16	640			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		325	496			13.00
14.00	Total (see instructions)	2,944	455	6,625	0.00	420.46	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,090	0	4,515	0.00	5.80	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	426.26	27.00
28.00	Observation Bed Days		306	1,529			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			40			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	57	72			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	704	79	1,727	1.00
2.00	HMO and other (see instructions)			297	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	704	79	1,727	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	0.00					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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

		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	15,269,789	0	15,269,789	600,264.75	25.44	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		0	0	0	0.00	0.00	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		1,059,666	0	1,059,666	27,342.66	38.76	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		265,036	20	265,056	9,234.53	28.70	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		927,388	0	927,388	24,988.84	37.11	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		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		978,551	0	978,551	25,217.15	38.80	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)		4,252,212	0	4,252,212			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		69,925	0	69,925			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		0	0	0			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

		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	0	163,471	163,471	4,112.16	39.75	26.00
27.00	Administrative & General	5.00	2,944,673	-159,679	2,784,994	121,686.90	22.89	27.00
28.00	Administrative & General under contract (see inst.)		213,668	0	213,668	817.80	261.27	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	409,787	0	409,787	14,100.75	29.06	30.00
31.00	Laundry & Linen Service	8.00	108,395	0	108,395	7,915.06	13.69	31.00
32.00	Housekeeping	9.00	394,229	0	394,229	33,769.17	11.67	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	539,117	-417,743	121,374	8,120.49	14.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	417,743	417,743	27,948.94	14.95	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	866,410	0	866,410	18,993.86	45.62	38.00
39.00	Central Services and Supply	14.00	108,578	0	108,578	5,199.75	20.88	39.00
40.00	Pharmacy	15.00	490,979	-490,979	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	411,952	0	411,952	18,703.83	22.03	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2018 12:22 pm

		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)		14,423,791	0	14,423,791	573,739.89	25.14	1.00
2.00	Excluded area salaries (see instructions)		265,036	20	265,056	9,234.53	28.70	2.00
3.00	Subtotal salaries (line 1 minus line 2)		14,158,755	-20	14,158,735	564,505.36	25.08	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,905,939	0	1,905,939	50,205.99	37.96	4.00
5.00	Subtotal wage-related costs (see inst.)		4,252,212	0	4,252,212	0.00	30.03	5.00
6.00	Total (sum of lines 3 thru 5)		20,316,906	-20	20,316,886	614,711.35	33.05	6.00
7.00	Total overhead cost (see instructions)		6,487,788	-487,187	6,000,601	261,368.71	22.96	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part IV | Date/Time Prepared: 5/29/2018 12:22 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	242,826	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	333,875	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	23,110	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)	2,386,796	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)	0	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)	35,391	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	226,521	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	1,030,723	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,618	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	24,277	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,322,137	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/29/2018 12:22 pm

	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	1,097,637	4,322,137	1.00
2.00	Hospital	927,388	4,322,137	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	170,249	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			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
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0120 | Component CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/29/2018 12:22 pm

Home Health Agency I | PPS

					1.00		
0.00	County				TAZEWELL		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	298	0	116	414	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	238.00	6.00	21.00	265.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.65	0.00	1.65	5.00
6.00	Direct Nursing Service			7.25	0.00	7.25	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.14	0.00	0.14	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).			37900			20.00
20.01				99914			20.01
		Full Episodes					
		Without Outliers	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	881	109	17	27	1,034	21.00
22.00	Skilled Nursing Visit Charges	153,294	18,966	2,958	4,698	179,916	22.00
23.00	Physical Therapy Visits	1,096	72	8	26	1,202	23.00
24.00	Physical Therapy Visit Charges	208,240	13,680	1,520	4,940	228,380	24.00
25.00	Occupational Therapy Visits	468	92	1	20	581	25.00
26.00	Occupational Therapy Visit Charges	89,856	17,664	192	3,840	111,552	26.00
27.00	Speech Pathology Visits	34	4	0	7	45	27.00
28.00	Speech Pathology Visit Charges	7,038	828	0	1,449	9,315	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	200	26	0	2	228	31.00
32.00	Home Health Aide Visit Charges	15,800	2,054	0	158	18,012	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,679	303	26	82	3,090	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)	474,228	53,192	4,670	15,085	547,175	35.00
36.00	Total Number of Episodes (standard/non outlier)	147		8	4	159	36.00
37.00	Total Number of Outlier Episodes		8		2	10	37.00
38.00	Total Non-Routine Medical Supply Charges	1,132	592	0	0	1,724	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/29/2018 12:22 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.243604	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,537,141	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	3,120,334	5.00
6.00	Medicaid charges	33,637,194	6.00
7.00	Medicaid cost (line 1 times line 6)	8,194,155	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,536,680	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)	1,536,680	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)	535,914	0	535,914	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	130,551	0	130,551	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)	130,551	0	130,551	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)	3,876,545	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	133,095	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	204,762	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,671,783	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	966,128	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,096,679	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,633,359	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		853,077	853,077	286,515	1,139,592	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,239,080	1,239,080	296,924	1,536,004	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,175,543	4,175,543	286,969	4,462,512	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,944,673	6,701,911	9,646,584	-711,353	8,935,231	5.00
7.00	00700	OPERATION OF PLANT	409,787	985,479	1,395,266	0	1,395,266	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,395	28,531	136,926	0	136,926	8.00
9.00	00900	HOUSEKEEPING	394,229	146,841	541,070	0	541,070	9.00
10.00	01000	DIETARY	539,117	335,524	874,641	-677,729	196,912	10.00
11.00	01100	CAFETERIA	0	0	0	677,729	677,729	11.00
13.00	01300	NURSING ADMINISTRATION	866,410	143,956	1,010,366	-71	1,010,295	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,578	189,484	298,062	-132,587	165,475	14.00
15.00	01500	PHARMACY	490,979	1,402,419	1,893,398	-1,659,397	234,001	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	411,952	136,198	548,150	0	548,150	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,874,958	506,264	3,381,222	-805,092	2,576,130	30.00
31.00	03100	INTENSIVE CARE UNIT	448,701	14,577	463,278	-1,124	462,154	31.00
43.00	04300	NURSERY	0	0	0	163,168	163,168	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,471,932	2,516,558	3,988,490	-2,309,944	1,678,546	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	468,028	468,028	52.00
53.00	05300	ANESTHESIOLOGY	0	953,610	953,610	-97,665	855,945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	837,349	267,991	1,105,340	-74,073	1,031,267	54.00
56.00	05600	RADIOISOTOPE	101,469	148,430	249,899	-1,047	248,852	56.00
57.00	05700	CT SCAN	151,259	101,818	253,077	-38,498	214,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,011	21,569	115,580	4,253	119,833	58.00
59.00	05900	CARDIAC CATHETERIZATION	182,763	330,704	513,467	-314,392	199,075	59.00
60.00	06000	LABORATORY	627,275	775,606	1,402,881	-67,754	1,335,127	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	149,997	149,997	42,440	192,437	63.00
65.00	06500	RESPIRATORY THERAPY	245,990	48,399	294,389	-42,751	251,638	65.00
66.00	06600	PHYSICAL THERAPY	0	523,703	523,703	-1,508	522,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,593	59,593	0	59,593	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,632	36,632	0	36,632	68.00
69.00	06900	ELECTROCARDIOLOGY	162,580	5,246	167,826	-943	166,883	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,383,014	2,383,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,210,061	1,210,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,664,033	1,664,033	73.00
76.00	03610	SLEEP LAB	0	352,637	352,637	-103,991	248,646	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	276,247	504,383	780,630	-21,874	758,756	90.00
91.00	09100	EMERGENCY	1,256,099	2,528,257	3,784,356	-193,563	3,590,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	253,906	213,845	467,751	-2,503	465,248	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		225,275	225,275	-225,275	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,258,659	26,623,137	41,881,796	0	41,881,796	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,130	995	12,125	0	12,125	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	15,269,789	26,624,132	41,893,921	0	41,893,921	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	88,581	1,228,173		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	194,874	1,730,878		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-500,560	3,961,952		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-724,780	8,210,451		5.00
7.00	00700	OPERATION OF PLANT	0	1,395,266		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,926		8.00
9.00	00900	HOUSEKEEPING	-42,764	498,306		9.00
10.00	01000	DIETARY	0	196,912		10.00
11.00	01100	CAFETERIA	-305,281	372,448		11.00
13.00	01300	NURSING ADMINISTRATION	-2,076	1,008,219		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-34,313	131,162		14.00
15.00	01500	PHARMACY	-638	233,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,138	541,012		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,220	2,574,910		30.00
31.00	03100	INTENSIVE CARE UNIT	0	462,154		31.00
43.00	04300	NURSERY	-30	163,138		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,678,546		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	468,028		52.00
53.00	05300	ANESTHESIOLOGY	-855,945	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,135	1,028,132		54.00
56.00	05600	RADIOISOTOPE	0	248,852		56.00
57.00	05700	CT SCAN	0	214,579		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	119,833		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	199,075		59.00
60.00	06000	LABORATORY	-45,000	1,290,127		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	192,437		63.00
65.00	06500	RESPIRATORY THERAPY	0	251,638		65.00
66.00	06600	PHYSICAL THERAPY	-5,524	516,671		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,593		67.00
68.00	06800	SPEECH PATHOLOGY	0	36,632		68.00
69.00	06900	ELECTROCARDIOLOGY	0	166,883		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,383,014		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,210,061		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,664,033		73.00
76.00	03610	SLEEP LAB	-27,650	220,996		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-277,073	481,683		90.00
91.00	09100	EMERGENCY	-2,193,166	1,397,627		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	465,248		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,742,838	37,138,958		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,125		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	LEASED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,742,838	37,151,083		200.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:22 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	417,743	259,986	1.00
	0		417,743	259,986	
	B - TO RECLASS BLOOD SALARIES FROM LAB				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	42,763	0	1.00
	0		42,763	0	
	C - TO RECLASS LDR EXPENSES				
1.00	NURSERY	43.00	157,899	5,233	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	452,915	15,010	2.00
	0		610,814	20,243	
	D - TO RECLASS CLINICAL ENGINEERING EXPE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	263,915	1.00
	0		0	263,915	
	E - TO RECLASS SUPPLY COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,383,014	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,210,061	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	3,593,075	
	F - TO RECLASS BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,194,698	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	1,194,698	
	G - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,920	1.00
2.00		0.00	0	0	2.00
	0		0	3,920	
	H - TO RECLASS HUMAN RESOURCES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	163,471	123,498	1.00
	0		163,471	123,498	
	I - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	225,275	1.00
	0		0	225,275	
	J - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	94,249	1.00
	0		0	94,249	
	K - TO RECLASS MRI LEASE EXPENSE				
1.00		0.00	0	0	1.00
	0		0	0	
	L - TO RECLASS MRI BUILDING UTILITIES				
1.00		0.00	0	0	1.00
	0		0	0	

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:22 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	M - TO RECLASS PHARMACY SALARIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,792	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	440	0	2.00
3.00	NURSERY	43.00	36	0	3.00
4.00	OPERATING ROOM	50.00	5,883	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	103	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	3,503	0	6.00
7.00	RADIOISOTOPE	56.00	754	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,518	0	8.00
9.00	CARDIAC CATHETERIZATION	59.00	21	0	9.00
10.00	LABORATORY	60.00	27	0	10.00
11.00	RESPIRATORY THERAPY	65.00	40	0	11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	469,335	0	12.00
13.00	SLEEP LAB	76.00	102	0	13.00
14.00	EMERGENCY	91.00	405	0	14.00
15.00	HOME HEALTH AGENCY	101.00	20	0	15.00
	0		490,979	0	
	N - TO RECLASS ANESTHESIOLOGY EXPENSE				
1.00	OPERATING ROOM	50.00	0	15,502	1.00
	0		0	15,502	
500.00	Grand Total: Increases		1,725,770	5,794,361	500.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	417,743	259,986	0		1.00
	0		417,743	259,986			
	B - TO RECLASS BLOOD SALARIES FROM LAB						
1.00	LABORATORY	60.00	42,763	0	0		1.00
	0		42,763	0			
	C - TO RECLASS LDR EXPENSES						
1.00	ADULTS & PEDIATRICS	30.00	610,814	20,243	0		1.00
2.00		0.00	0	0	0		2.00
	0		610,814	20,243			
	D - TO RECLASS CLINICAL ENGINEERING EXPE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	263,915	14		1.00
	0		0	263,915			
	E - TO RECLASS SUPPLY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	70,462	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	71	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	119,105	0		3.00
4.00	PHARMACY	15.00	0	9,681	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	174,036	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,119	0		6.00
8.00	OPERATING ROOM	50.00	0	2,328,071	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	80,469	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	77,109	0		10.00
11.00	RADIOISOTOPE	56.00	0	1,801	0		11.00
12.00	CT SCAN	57.00	0	34,224	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,265	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	314,009	0		14.00
15.00	LABORATORY	60.00	0	25,018	0		15.00
16.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	323	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	42,791	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	1,508	0		18.00
21.00	ELECTROCARDIOLOGY	69.00	0	943	0		21.00
22.00	SLEEP LAB	76.00	0	104,093	0		22.00
23.00	CLINIC	90.00	0	15,928	0		23.00
24.00	EMERGENCY	91.00	0	187,526	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	2,523	0		25.00
	0		0	3,593,075			
	F - TO RECLASS BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,482	0		1.00
2.00	PHARMACY	15.00	0	1,158,737	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	439	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	5	0		4.00
6.00	OPERATING ROOM	50.00	0	3,258	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	1,694	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17	0		8.00
10.00	CT SCAN	57.00	0	4,274	0		10.00
12.00	CARDIAC CATHETERIZATION	59.00	0	404	0		12.00
16.00	CLINIC	90.00	0	5,946	0		16.00
17.00	EMERGENCY	91.00	0	6,442	0		17.00
	0		0	1,194,698			
	G - TO RECLASS TELEPHONE EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	450	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,470	0		2.00
	0		0	3,920			
	H - TO RECLASS HUMAN RESOURCES						
1.00	ADMINISTRATIVE & GENERAL	5.00	163,471	123,498	0		1.00
	0		163,471	123,498			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	225,275	11		1.00
	0		0	225,275			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	94,249	0		1.00
	0		0	94,249			
	K - TO RECLASS MRI LEASE EXPENSE						
1.00		0.00	0	0	0		1.00
	0		0	0			
	L - TO RECLASS MRI BUILDING UTILITIES						
1.00		0.00	0	0	0		1.00
	0		0	0			

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - TO RECLASS PHARMACY SALARIES						
1.00	PHARMACY	15.00	490,979	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	0		490,979	0			
	N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	15,502	0		1.00
	0		0	15,502			
500.00	Grand Total: Decreases		1,725,770	5,794,361			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,449,581	800,419	0	800,419	0	1.00
2.00	Land Improvements	1,827,216	129,655	0	129,655	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	0	0	0	3.00
4.00	Building Improvements	21,045,919	3,637,558	0	3,637,558	831,312	4.00
5.00	Fixed Equipment	19,432,477	286,232	0	286,232	28,815	5.00
6.00	Movable Equipment	34,188,709	946,484	0	946,484	3,149,580	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	89,529,848	5,800,348	0	5,800,348	4,009,707	8.00
9.00	Reconciling Items	0	3,355,931	0	3,355,931	0	9.00
10.00	Total (line 8 minus line 9)	89,529,848	2,444,417	0	2,444,417	4,009,707	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,250,000	0	1.00
2.00	Land Improvements	1,956,871	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	3.00
4.00	Building Improvements	23,852,165	0	4.00
5.00	Fixed Equipment	19,689,894	0	5.00
6.00	Movable Equipment	31,985,613	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	91,320,489	0	8.00
9.00	Reconciling Items	3,355,931	0	9.00
10.00	Total (line 8 minus line 9)	87,964,558	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	863,191	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,239,080	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,102,271	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	-10,114	853,077		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,239,080		2.00
3.00	Total (sum of lines 1-2)	-10,114	2,092,157		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2018 12:22 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	59,334,876	0	59,334,876	0.649769	61,240	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	31,985,613	3,663	31,981,950	0.350231	33,009	2.00
3.00	Total (sum of lines 1-2)	91,320,489	3,663	91,316,826	1.000000	94,249	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	61,240	958,198	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	33,009	1,433,954	0	2.00
3.00	Total (sum of lines 1-2)	0	0	94,249	2,392,152	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	218,849	61,240	0	-10,114	1,228,173	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	33,009	0	263,915	1,730,878	2.00
3.00	Total (sum of lines 1-2)	218,849	94,249	0	253,801	2,959,051	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 12:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-6,426	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-2,542,889			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	-541,442			0	12.00
13.00	Laundry and linen service	B	-42,764	HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B	-216,031	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,138	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 12:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MOW & CATERING	B	-89,250	CAFETERIA	11.00	0	33.00
33.01	PAIN MANAGEMENT	B	-21,652	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICAL THERAPY OTHER INCOME	B	-5,524	PHYSICAL THERAPY	66.00	0	33.02
33.03	EDUCATION REVENUE	B	-2,046	NURSING ADMINISTRATION	13.00	0	33.03
33.04	SICKBAY REVENUE	B	-20	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	RADIOLOGY TRANSCRIPT REVENUE	B	-2,728	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	NURSERY OTHER INCOME	B	-30	NURSERY	43.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-600	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PURCHASE DISCOUNTS	B	-34,313	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	LIFEWAY PRESENTATION SERIES	B	-105,503	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	BOOK FAIR PROCEEDS	B	-1,455	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ADVERSTISING SALARY EXPENSE	A	-46,836	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ADVERTISING EXPENSE	A	-102,749	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING BENEFITS	A	-6,826	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	CRNA - PURCHASED SERVICES	A	-855,945	ANESTHESIOLOGY	53.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-444,436	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	HEALTHLINK ADMIN FEES	A	16,134	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PROMOTIONS	A	-922	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PUBLIC RELATIONS	A	-1,724	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PUBLIC RELATIONS	A	-30	NURSING ADMINISTRATION	13.00	0	33.19
33.20	PUBLIC RELATIONS	A	-1,200	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	PUBLIC RELATIONS	A	-407	RADIOLOGY-DIAGNOSTIC	54.00	0	33.21
33.22	FEDERAL EXCISE TAX	A	-638	PHARMACY	15.00	0	33.22
33.23	CHARITABLE CONTRIBUTION	A	-89,482	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	FA ADJUSTMENT FOR PURCHASE ACCTNG	A	95,007	CAP REL COSTS-BLDG & FIXT	1.00	9	33.24
33.25	FA ADJUSTMENT FOR PURCHASE ACCTNG	A	317,027	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,742,838				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2018 12:22 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL REL COSTS- MME-PROGR	526,766	648,919	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE/FINANCE/IS-UN	4,558,671	2,809,124	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PROVIDER TAX HOSPITAL	0	2,119,538	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES-UNITY POINT	236,653	285,951	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,322,090	5,863,532	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/29/2018 12:22 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-122,153	9		1.00
2.00	1,749,547	0		2.00
3.00	-2,119,538	0		3.00
4.00	-49,298	0		4.00
5.00	-541,442			5.00

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

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

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

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

6.00	HEALTHCARE MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 12:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	76.00	SLEEP LAB	27,650	27,650	0	0	0	1.00
2.00	91.00	EMERGENCY	2,193,166	2,193,166	0	0	0	2.00
3.00	90.00	CLINIC	277,073	277,073	0	0	0	3.00
4.00	60.00	LABORATORY	45,000	45,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,542,889	2,542,889	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	76.00	SLEEP LAB	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	76.00	SLEEP LAB	0	0	0	27,650		1.00
2.00	91.00	EMERGENCY	0	0	0	2,193,166		2.00
3.00	90.00	CLINIC	0	0	0	277,073		3.00
4.00	60.00	LABORATORY	0	0	0	45,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,542,889		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,228,173	1,228,173				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,730,878		1,730,878			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,961,952	4,972	71	3,966,995		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,210,451	407,964	645,876	720,465	9,984,756	5.00
7.00	00700	OPERATION OF PLANT	1,395,266	168,272	10,850	107,974	1,682,362	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,926	12,603	16,917	28,561	195,007	8.00
9.00	00900	HOUSEKEEPING	498,306	1,001	6,120	103,875	609,302	9.00
10.00	01000	DIETARY	196,912	23,994	11,011	31,981	263,898	10.00
11.00	01100	CAFETERIA	372,448	6,712	10,839	110,071	500,070	11.00
13.00	01300	NURSING ADMINISTRATION	1,008,219	32,402	27,171	228,290	1,296,082	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	131,162	17,467	49,922	28,609	227,160	14.00
15.00	01500	PHARMACY	233,363	5,778	7,990	0	247,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	541,012	14,438	545	108,545	664,540	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,574,910	139,108	48,561	596,693	3,359,272	30.00
31.00	03100	INTENSIVE CARE UNIT	462,154	13,389	43,985	118,228	637,756	31.00
43.00	04300	NURSERY	163,138	3,480	2,972	41,614	211,204	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,678,546	69,977	243,909	389,388	2,381,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	468,028	11,287	8,525	119,365	607,205	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,028,132	52,577	276,396	221,555	1,578,660	54.00
56.00	05600	RADIOISOTOPE	248,852	2,939	3,044	26,935	281,770	56.00
57.00	05700	CT SCAN	214,579	2,587	2,098	39,855	259,119	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	119,833	6,826	189,215	26,488	342,362	58.00
59.00	05900	CARDIAC CATHETERIZATION	199,075	2,570	7,114	48,162	256,921	59.00
60.00	06000	LABORATORY	1,290,127	20,219	31,844	154,020	1,496,210	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	192,437	0	1,304	11,268	205,009	63.00
65.00	06500	RESPIRATORY THERAPY	251,638	5,126	13,409	64,826	334,999	65.00
66.00	06600	PHYSICAL THERAPY	516,671	13,269	1,364	0	531,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,593	1,612	0	0	61,205	67.00
68.00	06800	SPEECH PATHOLOGY	36,632	6,208	0	0	42,840	68.00
69.00	06900	ELECTROCARDIOLOGY	166,883	17,891	29,861	42,838	257,473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,383,014	0	0	0	2,383,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,210,061	0	0	0	1,210,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,664,033	0	0	123,665	1,787,698	73.00
76.00	03610	SLEEP LAB	220,996	2,486	4,396	27	227,905	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	481,683	6,789	3,701	72,788	564,961	90.00
91.00	09100	EMERGENCY	1,397,627	49,423	25,163	331,075	1,803,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	465,248	7,964	6,705	66,901	546,818	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,138,958	1,131,330	1,730,878	3,964,062	37,039,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,125	13,396	0	2,933	28,454	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	61,428	0	0	61,428	192.00
194.00	07950	VACANT SPACE	0	3,312	0	0	3,312	194.00
194.01	07951	LEASED SPACE	0	17,041	0	0	17,041	194.01
194.02	07952	FOUNDATION	0	1,666	0	0	1,666	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,151,083	1,228,173	1,730,878	3,966,995	37,151,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,984,756					5.00
7.00	00700	OPERATION OF PLANT	618,339	2,300,701				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,673	44,820	311,500			8.00
9.00	00900	HOUSEKEEPING	223,944	3,560	18,534	855,340		9.00
10.00	01000	DIETARY	96,994	85,327	527	32,404	479,150	10.00
11.00	01100	CAFETERIA	183,797	23,867	0	9,064	0	11.00
13.00	01300	NURSING ADMINISTRATION	476,365	115,227	0	43,758	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,491	62,117	2,735	23,589	0	14.00
15.00	01500	PHARMACY	90,831	20,546	0	7,803	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	244,246	51,342	0	19,498	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,234,666	494,689	62,464	187,864	428,885	30.00
31.00	03100	INTENSIVE CARE UNIT	234,402	47,615	41,160	18,082	50,265	31.00
43.00	04300	NURSERY	77,626	12,376	6,966	4,700	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	875,419	248,850	58,105	94,503	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	223,173	40,137	19,980	15,242	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	580,224	186,972	27,434	71,004	0	54.00
56.00	05600	RADIOISOTOPE	103,562	10,452	0	3,969	0	56.00
57.00	05700	CT SCAN	95,237	9,198	0	3,493	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	125,832	24,273	2,545	9,218	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	94,429	9,138	0	3,470	0	59.00
60.00	06000	LABORATORY	549,920	71,900	3,147	27,305	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	75,349	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	123,126	18,229	0	6,923	0	65.00
66.00	06600	PHYSICAL THERAPY	195,277	47,185	7,482	17,919	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,495	5,734	0	2,177	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,745	22,075	0	8,383	0	68.00
69.00	06900	ELECTROCARDIOLOGY	94,632	63,622	0	24,161	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	875,858	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	444,748	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,054	0	0	0	0	73.00
76.00	03610	SLEEP LAB	83,765	8,840	0	3,357	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	207,647	24,142	0	9,168	0	90.00
91.00	09100	EMERGENCY	662,784	175,755	56,141	66,745	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	200,979	28,323	0	10,756	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,943,629	1,956,311	307,220	724,555	479,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,458	47,639	0	18,091	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,577	218,448	4,280	82,958	0	192.00
194.00	07950	VACANT SPACE	1,217	11,778	0	4,473	0	194.00
194.01	07951	LEASED SPACE	6,263	60,600	0	23,013	0	194.01
194.02	07952	FOUNDATION	612	5,925	0	2,250	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)	9,984,756	2,300,701	311,500	855,340	479,150	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	716,798					11.00
13.00	01300	NURSING ADMINISTRATION	37,269	1,968,701				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,201	0	409,293			14.00
15.00	01500	PHARMACY	0	0	392	366,703		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,698	0	457	0	1,016,781	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,673	1,631,124	2,689	331	604,237	30.00
31.00	03100	INTENSIVE CARE UNIT	31,421	190,184	93	0	29,365	31.00
43.00	04300	NURSERY	9,821	147,393	112	27	44,240	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,029	0	3,775	4,428	217,314	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,129	0	323	78	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,542	0	1,230	2,636	0	54.00
56.00	05600	RADIOISOTOPE	4,924	0	16	567	0	56.00
57.00	05700	CT SCAN	10,283	0	16	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,305	0	83	4,906	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,603	0	440	16	0	59.00
60.00	06000	LABORATORY	48,097	0	1,650	20	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,509	0	16	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	17,955	0	128	30	83,125	65.00
66.00	06600	PHYSICAL THERAPY	0	0	240	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,038	0	116	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	260,876	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	132,468	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,728	0	0	353,267	0	73.00
76.00	03610	SLEEP LAB	0	0	540	77	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,151	0	633	0	0	90.00
91.00	09100	EMERGENCY	79,082	0	2,467	305	38,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	435	15	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	714,458	1,968,701	409,195	366,703	1,016,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,340	0	98	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	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)	716,798	1,968,701	409,293	366,703	1,016,781	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,167,894	0	8,167,894		30.00
31.00	03100	INTENSIVE CARE UNIT	1,280,343	0	1,280,343		31.00
43.00	04300	NURSERY	514,465	0	514,465		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,984,243	0	3,984,243		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	934,267	0	934,267		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,702	0	2,510,702		54.00
56.00	05600	RADIOISOTOPE	405,260	0	405,260		56.00
57.00	05700	CT SCAN	377,346	0	377,346		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	514,524	0	514,524		58.00
59.00	05900	CARDIAC CATHETERIZATION	374,017	0	374,017		59.00
60.00	06000	LABORATORY	2,198,249	0	2,198,249		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	283,883	0	283,883		63.00
65.00	06500	RESPIRATORY THERAPY	584,515	0	584,515		65.00
66.00	06600	PHYSICAL THERAPY	799,407	0	799,407		66.00
67.00	06700	OCCUPATIONAL THERAPY	91,611	0	91,611		67.00
68.00	06800	SPEECH PATHOLOGY	89,043	0	89,043		68.00
69.00	06900	ELECTROCARDIOLOGY	450,042	0	450,042		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,519,748	0	3,519,748		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,787,277	0	1,787,277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,822,747	0	2,822,747		73.00
76.00	03610	SLEEP LAB	324,484	0	324,484		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	829,702	0	829,702		90.00
91.00	09100	EMERGENCY	2,885,067	0	2,885,067		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	787,326	0	787,326		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,516,162	0	36,516,162		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	107,080	0	107,080		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	389,691	0	389,691		192.00
194.00	07950	VACANT SPACE	20,780	0	20,780		194.00
194.01	07951	LEASED SPACE	106,917	0	106,917		194.01
194.02	07952	FOUNDATION	10,453	0	10,453		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	37,151,083	0	37,151,083		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,972	71	5,043	5,043	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,020	407,964	645,876	1,080,860	916	5.00
7.00	00700	OPERATION OF PLANT	4,611	168,272	10,850	183,733	137	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,603	16,917	29,520	36	8.00
9.00	00900	HOUSEKEEPING	0	1,001	6,120	7,121	132	9.00
10.00	01000	DIETARY	0	23,994	11,011	35,005	41	10.00
11.00	01100	CAFETERIA	0	6,712	10,839	17,551	140	11.00
13.00	01300	NURSING ADMINISTRATION	0	32,402	27,171	59,573	290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,543	17,467	49,922	68,932	36	14.00
15.00	01500	PHARMACY	132,302	5,778	7,990	146,070	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,438	545	14,983	138	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,417	139,108	48,561	212,086	759	30.00
31.00	03100	INTENSIVE CARE UNIT	3,405	13,389	43,985	60,779	150	31.00
43.00	04300	NURSERY	0	3,480	2,972	6,452	53	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,600	69,977	243,909	333,486	495	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,287	8,525	19,812	152	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,347	52,577	276,396	334,320	282	54.00
56.00	05600	RADIOISOTOPE	0	2,939	3,044	5,983	34	56.00
57.00	05700	CT SCAN	0	2,587	2,098	4,685	51	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,826	189,215	196,041	34	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,570	7,114	9,684	61	59.00
60.00	06000	LABORATORY	0	20,219	31,844	52,063	196	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,304	1,304	14	63.00
65.00	06500	RESPIRATORY THERAPY	128	5,126	13,409	18,663	82	65.00
66.00	06600	PHYSICAL THERAPY	0	13,269	1,364	14,633	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,612	0	1,612	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,208	0	6,208	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,891	29,861	47,752	54	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	157	73.00
76.00	03610	SLEEP LAB	0	2,486	4,396	6,882	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,789	3,701	10,490	93	90.00
91.00	09100	EMERGENCY	240	49,423	25,163	74,826	421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,166	7,964	6,705	22,835	85	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	226,779	1,131,330	1,730,878	3,088,987	5,039	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,396	0	13,396	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	61,428	0	61,428	0	192.00
194.00	07950	VACANT SPACE	0	3,312	0	3,312	0	194.00
194.01	07951	LEASED SPACE	0	17,041	0	17,041	0	194.01
194.02	07952	FOUNDATION	0	1,666	0	1,666	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	226,779	1,228,173	1,730,878	3,185,830	5,043	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,081,776					5.00
7.00	00700	OPERATION OF PLANT	66,992	250,862				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,765	4,887	42,208			8.00
9.00	00900	HOUSEKEEPING	24,262	388	2,511	34,414		9.00
10.00	01000	DIETARY	10,508	9,304	71	1,304	56,233	10.00
11.00	01100	CAFETERIA	19,913	2,602	0	365	0	11.00
13.00	01300	NURSING ADMINISTRATION	51,610	12,564	0	1,761	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,046	6,773	371	949	0	14.00
15.00	01500	PHARMACY	9,841	2,240	0	314	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,462	5,598	0	784	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,778	53,941	8,465	7,555	50,334	30.00
31.00	03100	INTENSIVE CARE UNIT	25,395	5,192	5,577	728	5,899	31.00
43.00	04300	NURSERY	8,410	1,349	944	189	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,844	27,134	7,873	3,802	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,179	4,376	2,707	613	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,862	20,387	3,717	2,857	0	54.00
56.00	05600	RADIOISOTOPE	11,220	1,140	0	160	0	56.00
57.00	05700	CT SCAN	10,318	1,003	0	141	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,633	2,647	345	371	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,231	996	0	140	0	59.00
60.00	06000	LABORATORY	59,579	7,840	426	1,099	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,163	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	13,340	1,988	0	279	0	65.00
66.00	06600	PHYSICAL THERAPY	21,157	5,145	1,014	721	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,437	625	0	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,706	2,407	0	337	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,253	6,937	0	972	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,892	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,185	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,186	0	0	0	0	73.00
76.00	03610	SLEEP LAB	9,075	964	0	135	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,497	2,632	0	369	0	90.00
91.00	09100	EMERGENCY	71,807	19,164	7,607	2,685	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	21,774	3,088	0	433	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,077,320	213,311	41,628	29,151	56,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,133	5,194	0	728	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,446	23,819	580	3,338	0	192.00
194.00	07950	VACANT SPACE	132	1,284	0	180	0	194.00
194.01	07951	LEASED SPACE	679	6,608	0	926	0	194.01
194.02	07952	FOUNDATION	66	646	0	91	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)	1,081,776	250,862	42,208	34,414	56,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	40,571					11.00
13.00	01300	NURSING ADMINISTRATION	2,109	127,907				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	577	0	86,684			14.00
15.00	01500	PHARMACY	0	0	83	158,548		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,077	0	97	0	50,139	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,152	105,975	570	143	29,796	30.00
31.00	03100	INTENSIVE CARE UNIT	1,778	12,356	20	0	1,448	31.00
43.00	04300	NURSERY	556	9,576	24	12	2,182	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,662	0	799	1,914	10,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,592	0	68	34	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,540	0	261	1,140	0	54.00
56.00	05600	RADIOISOTOPE	279	0	3	245	0	56.00
57.00	05700	CT SCAN	582	0	3	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300	0	18	2,121	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	544	0	93	7	0	59.00
60.00	06000	LABORATORY	2,722	0	349	9	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	0	3	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,016	0	27	13	4,099	65.00
66.00	06600	PHYSICAL THERAPY	0	0	51	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	568	0	24	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	55,253	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,055	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,400	0	0	152,739	0	73.00
76.00	03610	SLEEP LAB	0	0	114	33	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,310	0	134	0	0	90.00
91.00	09100	EMERGENCY	4,476	0	522	132	1,898	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	92	6	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,439	127,907	86,663	158,548	50,139	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	132	0	21	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	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)	40,571	127,907	86,684	158,548	50,139	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	612,554	0	612,554		30.00
31.00	03100	INTENSIVE CARE UNIT	119,322	0	119,322		31.00
43.00	04300	NURSERY	29,747	0	29,747		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	486,725	0	486,725		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,533	0	53,533		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,366	0	429,366		54.00
56.00	05600	RADIOISOTOPE	19,064	0	19,064		56.00
57.00	05700	CT SCAN	16,783	0	16,783		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,510	0	215,510		58.00
59.00	05900	CARDIAC CATHETERIZATION	21,756	0	21,756		59.00
60.00	06000	LABORATORY	124,283	0	124,283		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,683	0	9,683		63.00
65.00	06500	RESPIRATORY THERAPY	39,507	0	39,507		65.00
66.00	06600	PHYSICAL THERAPY	42,721	0	42,721		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,762	0	4,762		67.00
68.00	06800	SPEECH PATHOLOGY	10,658	0	10,658		68.00
69.00	06900	ELECTROCARDIOLOGY	66,560	0	66,560		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,145	0	150,145		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,240	0	76,240		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,482	0	225,482		73.00
76.00	03610	SLEEP LAB	17,203	0	17,203		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	37,525	0	37,525		90.00
91.00	09100	EMERGENCY	183,538	0	183,538		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	48,313	0	48,313		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,040,980	0	3,040,980		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,608	0	20,608		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	91,611	0	91,611		192.00
194.00	07950	VACANT SPACE	4,908	0	4,908		194.00
194.01	07951	LEASED SPACE	25,254	0	25,254		194.01
194.02	07952	FOUNDATION	2,469	0	2,469		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,185,830	0	3,185,830		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	365,623					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,435,654				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	59	15,055,665			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,450	535,713	2,734,361	-9,984,756	27,166,327	5.00
7.00	00700	OPERATION OF PLANT	50,094	8,999	409,787	0	1,682,362	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	14,032	108,395	0	195,007	8.00
9.00	00900	HOUSEKEEPING	298	5,076	394,229	0	609,302	9.00
10.00	01000	DIETARY	7,143	9,133	121,374	0	263,898	10.00
11.00	01100	CAFETERIA	1,998	8,990	417,743	0	500,070	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	22,537	866,410	0	1,296,082	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	41,407	108,578	0	227,160	14.00
15.00	01500	PHARMACY	1,720	6,627	0	0	247,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	452	411,952	0	664,540	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	40,278	2,264,584	0	3,359,272	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	36,483	448,701	0	637,756	31.00
43.00	04300	NURSERY	1,036	2,465	157,935	0	211,204	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	202,307	1,477,815	0	2,381,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	7,071	453,018	0	607,205	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	229,253	840,852	0	1,578,660	54.00
56.00	05600	RADIOISOTOPE	875	2,525	102,223	0	281,770	56.00
57.00	05700	CT SCAN	770	1,740	151,259	0	259,119	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	156,942	100,529	0	342,362	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	5,901	182,784	0	256,921	59.00
60.00	06000	LABORATORY	6,019	26,413	584,539	0	1,496,210	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,082	42,763	0	205,009	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	11,122	246,030	0	334,999	65.00
66.00	06600	PHYSICAL THERAPY	3,950	1,131	0	0	531,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	0	0	61,205	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	0	0	42,840	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	24,768	162,580	0	257,473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,383,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,210,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	469,335	0	1,787,698	73.00
76.00	03610	SLEEP LAB	740	3,646	102	0	227,905	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	3,070	276,247	0	564,961	90.00
91.00	09100	EMERGENCY	14,713	20,871	1,256,504	0	1,803,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,371	5,561	253,906	0	546,818	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	336,793	1,435,654	15,044,535	-9,984,756	27,054,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	11,130	0	28,454	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	61,428	192.00
194.00	07950	VACANT SPACE	986	0	0	0	3,312	194.00
194.01	07951	LEASED SPACE	5,073	0	0	0	17,041	194.01
194.02	07952	FOUNDATION	496	0	0	0	1,666	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)	1,228,173	1,730,878	3,966,995		9,984,756	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.359124	1.205637	0.263489		0.367542	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,043		1,081,776	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000335		0.039820	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	192,599					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	259,005				8.00
9.00	00900	HOUSEKEEPING	298	15,411	188,549			9.00
10.00	01000	DIETARY	7,143	438	7,143	34,660		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	26,349	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	9,646	0	1,370	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	2,274	5,200	0	375	14.00
15.00	01500	PHARMACY	1,720	0	1,720	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	4,298	0	1,349	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	51,936	41,412	31,024	5,943	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	34,224	3,986	3,636	1,155	31.00
43.00	04300	NURSERY	1,036	5,792	1,036	0	361	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	48,313	20,832	0	3,677	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	16,613	3,360	0	1,034	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	22,811	15,652	0	2,299	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	181	56.00
57.00	05700	CT SCAN	770	0	770	0	378	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	2,116	2,032	0	195	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	353	59.00
60.00	06000	LABORATORY	6,019	2,617	6,019	0	1,768	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	129	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	660	65.00
66.00	06600	PHYSICAL THERAPY	3,950	6,221	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	0	5,326	0	369	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	909	73.00
76.00	03610	SLEEP LAB	740	0	740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	0	2,021	0	851	90.00
91.00	09100	EMERGENCY	14,713	46,680	14,713	0	2,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,371	0	2,371	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	163,769	255,446	159,719	34,660	26,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	86	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	3,559	18,287	0	0	192.00
194.00	07950	VACANT SPACE	986	0	986	0	0	194.00
194.01	07951	LEASED SPACE	5,073	0	5,073	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	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)	2,300,701	311,500	855,340	479,150	716,798	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.945550	1.202679	4.536434	13.824293	27.203993	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	250,862	42,208	34,414	56,233	40,571	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.302509	0.162962	0.182520	1.622418	1.539755	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:22 pm

		Cost Center Description	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,625					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,738,776				14.00
15.00	01500	PHARMACY	0	3,585	1,240,137			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,175	0	29,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,489	24,566	1,121	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	640	852	0	839		31.00
43.00	04300	NURSERY	496	1,027	92	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,482	14,974	6,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,946	263	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,238	8,916	0		54.00
56.00	05600	RADIOISOTOPE	0	143	1,919	0		56.00
57.00	05700	CT SCAN	0	148	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	761	16,591	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,020	53	0		59.00
60.00	06000	LABORATORY	0	15,073	68	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	149	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,165	101	2,375		65.00
66.00	06600	PHYSICAL THERAPY	0	2,196	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	2	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,056	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,383,014	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,210,061	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,194,698	0		73.00
76.00	03610	SLEEP LAB	0	4,934	260	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,780	0	0		90.00
91.00	09100	EMERGENCY	0	22,533	1,031	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,975	50	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,625	3,737,881	1,240,137	29,051		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	895	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	VACANT SPACE	0	0	0	0		194.00
194.01	07951	LEASED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	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)	1,968,701	409,293	366,703	1,016,781		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	297.162415	0.109472	0.295696	34.999862		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	127,907	86,684	158,548	50,139		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	19.306717	0.023185	0.127847	1.725896		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:22 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,167,894		8,167,894	0	8,167,894	30.00
31.00	03100	INTENSIVE CARE UNIT	1,280,343		1,280,343	0	1,280,343	31.00
43.00	04300	NURSERY	514,465		514,465	0	514,465	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,984,243		3,984,243	0	3,984,243	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	934,267		934,267	0	934,267	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,702		2,510,702	0	2,510,702	54.00
56.00	05600	RADIOISOTOPE	405,260		405,260	0	405,260	56.00
57.00	05700	CT SCAN	377,346		377,346	0	377,346	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	514,524		514,524	0	514,524	58.00
59.00	05900	CARDIAC CATHETERIZATION	374,017		374,017	0	374,017	59.00
60.00	06000	LABORATORY	2,198,249		2,198,249	0	2,198,249	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	283,883		283,883	0	283,883	63.00
65.00	06500	RESPIRATORY THERAPY	584,515	0	584,515	0	584,515	65.00
66.00	06600	PHYSICAL THERAPY	799,407	0	799,407	0	799,407	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,611	0	91,611	0	91,611	67.00
68.00	06800	SPEECH PATHOLOGY	89,043	0	89,043	0	89,043	68.00
69.00	06900	ELECTROCARDIOLOGY	450,042		450,042	0	450,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,519,748		3,519,748	0	3,519,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,787,277		1,787,277	0	1,787,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,822,747		2,822,747	0	2,822,747	73.00
76.00	03610	SLEEP LAB	324,484		324,484	0	324,484	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	829,702		829,702	0	829,702	90.00
91.00	09100	EMERGENCY	2,885,067		2,885,067	0	2,885,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,779,527		1,779,527		1,779,527	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	787,326		787,326		787,326	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,295,689	0	38,295,689	0	38,295,689	200.00
201.00		Less Observation Beds	1,779,527		1,779,527		1,779,527	201.00
202.00		Total (see instructions)	36,516,162	0	36,516,162	0	36,516,162	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:22 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,554,900		7,554,900			30.00
31.00	03100	INTENSIVE CARE UNIT	1,370,297		1,370,297			31.00
43.00	04300	NURSERY	394,856		394,856			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,407,865	20,307,172	25,715,037	0.154938	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,046,625	93,883	1,140,508	0.819167	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,457,529	12,683,459	14,140,988	0.177548	0.000000	54.00
56.00	05600	RADIOISOTOPE	298,238	3,556,040	3,854,278	0.105146	0.000000	56.00
57.00	05700	CT SCAN	3,010,365	20,387,202	23,397,567	0.016128	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	231,589	3,930,685	4,162,274	0.123616	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	257,549	2,272,502	2,530,051	0.147830	0.000000	59.00
60.00	06000	LABORATORY	865,518	3,069,188	3,934,706	0.558682	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	119,540	168,325	287,865	0.986167	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,242,610	156,893	1,399,503	0.417659	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	796,604	1,737,054	2,533,658	0.315515	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,446	77,050	338,496	0.270641	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	101,188	116,088	217,276	0.409815	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,697,328	4,798,959	6,496,287	0.069277	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,704,389	1,886,134	4,590,523	0.766742	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,123,455	1,247,106	3,370,561	0.530261	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,160,894	6,533,367	11,694,261	0.241379	0.000000	73.00
76.00	03610	SLEEP LAB	5,984	1,064,602	1,070,586	0.303090	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	466	1,761,541	1,762,007	0.470885	0.000000	90.00
91.00	09100	EMERGENCY	3,412,886	21,622,968	25,035,854	0.115237	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	281,809	1,723,902	2,005,711	0.887230	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	901,645	901,645			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,803,930	110,095,765	149,899,695			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,803,930	110,095,765	149,899,695			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:22 pm

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		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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.154938		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.819167		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177548		54.00
56.00	05600	RADIOISOTOPE	0.105146		56.00
57.00	05700	CT SCAN	0.016128		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123616		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.147830		59.00
60.00	06000	LABORATORY	0.558682		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.986167		63.00
65.00	06500	RESPIRATORY THERAPY	0.417659		65.00
66.00	06600	PHYSICAL THERAPY	0.315515		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270641		67.00
68.00	06800	SPEECH PATHOLOGY	0.409815		68.00
69.00	06900	ELECTROCARDIOLOGY	0.069277		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.766742		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530261		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241379		73.00
76.00	03610	SLEEP LAB	0.303090		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.470885		90.00
91.00	09100	EMERGENCY	0.115237		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.887230		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/29/2018 12:22 pm

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	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	612,554	0	612,554	7,018	87.28	30.00
31.00	INTENSIVE CARE UNIT	119,322		119,322	640	186.44	31.00
43.00	NURSERY	29,747		29,747	496	59.97	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	761,623		761,623	8,154		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	2,735	238,711				30.00
31.00	INTENSIVE CARE UNIT	209	38,966				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	2,944	277,677				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 12:22 pm

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		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	486,725	25,715,037	0.018928	2,079,694	39,364	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,533	1,140,508	0.046938	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,366	14,140,988	0.030363	756,373	22,966	54.00
56.00	05600	RADIOISOTOPE	19,064	3,854,278	0.004946	195,772	968	56.00
57.00	05700	CT SCAN	16,783	23,397,567	0.000717	1,317,977	945	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,510	4,162,274	0.051777	99,611	5,158	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,756	2,530,051	0.008599	233,897	2,011	59.00
60.00	06000	LABORATORY	124,283	3,934,706	0.031586	379,199	11,977	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,683	287,865	0.033637	65,044	2,188	63.00
65.00	06500	RESPIRATORY THERAPY	39,507	1,399,503	0.028229	739,251	20,868	65.00
66.00	06600	PHYSICAL THERAPY	42,721	2,533,658	0.016861	475,270	8,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,762	338,496	0.014068	160,871	2,263	67.00
68.00	06800	SPEECH PATHOLOGY	10,658	217,276	0.049053	68,285	3,350	68.00
69.00	06900	ELECTROCARDIOLOGY	66,560	6,496,287	0.010246	892,025	9,140	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,145	4,590,523	0.032708	1,383,658	45,257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,240	3,370,561	0.022619	1,163,990	26,328	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,482	11,694,261	0.019281	2,497,161	48,148	73.00
76.00	03610	SLEEP LAB	17,203	1,070,586	0.016069	5,345	86	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,525	1,762,007	0.021297	361	8	90.00
91.00	09100	EMERGENCY	183,538	25,035,854	0.007331	1,750,550	12,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	133,456	2,005,711	0.066538	146,520	9,749	92.00
200.00		Total (lines 50 through 199)	2,364,500	139,677,997		14,410,854	271,621	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/29/2018 12:22 pm

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
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	7,018	0.00	2,735	30.00
31.00	03100	INTENSIVE CARE UNIT		0	640	0.00	209	31.00
43.00	04300	NURSERY		0	496	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	8,154		2,944	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
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 12:22 pm

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		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 PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 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	25,715,037	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,140,508	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,140,988	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,854,278	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	23,397,567	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,162,274	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,530,051	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	3,934,706	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	287,865	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,399,503	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,533,658	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	338,496	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	217,276	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,496,287	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,590,523	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,370,561	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,694,261	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	1,070,586	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,762,007	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,035,854	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,005,711	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	139,677,997		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 12:22 pm

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	2,079,694	0	5,256,557	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	756,373	0	3,301,431	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	195,772	0	1,302,129	0	56.00
57.00	05700	CT SCAN	0.000000	1,317,977	0	6,504,719	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	99,611	0	1,287,151	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	233,897	0	1,565,546	0	59.00
60.00	06000	LABORATORY	0.000000	379,199	0	414,362	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	65,044	0	115,227	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	739,251	0	49,965	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	475,270	0	39,340	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	160,871	0	12,533	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68,285	0	5,051	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	892,025	0	1,679,608	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,383,658	0	594,927	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,163,990	0	687,118	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,497,161	0	2,148,011	0	73.00
76.00	03610	SLEEP LAB	0.000000	5,345	0	511,785	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	361	0	301,717	0	90.00
91.00	09100	EMERGENCY	0.000000	1,750,550	0	3,781,404	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	146,520	0	369,559	0	92.00
200.00		Total (lines 50 through 199)		14,410,854	0	29,928,140	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.154938	5,256,557	0	0	814,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.819167	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177548	3,301,431	0	0	586,162	54.00
56.00	05600	RADIOISOTOPE	0.105146	1,302,129	0	0	136,914	56.00
57.00	05700	CT SCAN	0.016128	6,504,719	0	0	104,908	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123616	1,287,151	0	0	159,112	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.147830	1,565,546	0	0	231,435	59.00
60.00	06000	LABORATORY	0.558682	414,362	16	0	231,497	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.986167	115,227	0	0	113,633	63.00
65.00	06500	RESPIRATORY THERAPY	0.417659	49,965	0	0	20,868	65.00
66.00	06600	PHYSICAL THERAPY	0.315515	39,340	0	0	12,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270641	12,533	0	0	3,392	67.00
68.00	06800	SPEECH PATHOLOGY	0.409815	5,051	0	0	2,070	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069277	1,679,608	0	0	116,358	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.766742	594,927	0	0	456,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530261	687,118	0	0	364,352	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241379	2,148,011	0	7,793	518,485	73.00
76.00	03610	SLEEP LAB	0.303090	511,785	0	0	155,117	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.470885	301,717	0	0	142,074	90.00
91.00	09100	EMERGENCY	0.115237	3,781,404	0	0	435,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.887230	369,559	0	0	327,884	92.00
200.00		Subtotal (see instructions)		29,928,140	16	7,793	4,933,027	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		29,928,140	16	7,793	4,933,027	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	9	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,881		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		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 PART)	0	0		92.00
200.00		Subtotal (see instructions)	9	1,881		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9	1,881		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:22 pm

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)	7,018	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,018	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)	5,489	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)	2,735	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)	8,167,894	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)	8,167,894	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)	8,167,894	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,163.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,183,130	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)	3,183,130	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:22 pm

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	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	1,280,343	640	2,000.54	209	418,113	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)	4,027,679	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,628,922	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)	277,677	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	271,621	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	549,298	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,079,624	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)	1,529	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,163.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,779,527	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:22 pm

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	612,554	8,167,894	0.074995	1,779,527	133,456	90.00
91.00	Nursing School cost	0	8,167,894	0.000000	1,779,527	0	91.00
92.00	Allied health cost	0	8,167,894	0.000000	1,779,527	0	92.00
93.00	All other Medical Education	0	8,167,894	0.000000	1,779,527	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 12:22 pm

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		3,610,416		30.00
31.00	03100	INTENSIVE CARE UNIT		507,285		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.154938	2,079,694	322,224	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.819167	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177548	756,373	134,293	54.00
56.00	05600	RADIOISOTOPE	0.105146	195,772	20,585	56.00
57.00	05700	CT SCAN	0.016128	1,317,977	21,256	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123616	99,611	12,314	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.147830	233,897	34,577	59.00
60.00	06000	LABORATORY	0.558682	379,199	211,852	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.986167	65,044	64,144	63.00
65.00	06500	RESPIRATORY THERAPY	0.417659	739,251	308,755	65.00
66.00	06600	PHYSICAL THERAPY	0.315515	475,270	149,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270641	160,871	43,538	67.00
68.00	06800	SPEECH PATHOLOGY	0.409815	68,285	27,984	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069277	892,025	61,797	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.766742	1,383,658	1,060,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530261	1,163,990	617,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241379	2,497,161	602,762	73.00
76.00	03610	SLEEP LAB	0.303090	5,345	1,620	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.470885	361	170	90.00
91.00	09100	EMERGENCY	0.115237	1,750,550	201,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.887230	146,520	129,997	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,410,854	4,027,679	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)		14,410,854		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 12:22 pm
	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)	3,083,420	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,850,052	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)	53,863	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
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)	100.76	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 which 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)	2.87	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.59	31.00
32.00	Sum of lines 30 and 31	22.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.75	33.00
34.00	Disproportionate share adjustment (see instructions)	95,586	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 12:22 pm
	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	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	475,745	469,205	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	199,422	118,265	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	317,687		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
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	5,400,608		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)	5,400,608	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	418,507	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)	5,819,115	59.00
60.00	Primary payer payments	3,587	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,815,528	61.00
62.00	Deductibles billed to program beneficiaries	669,844	62.00
63.00	Coinsurance billed to program beneficiaries	2,961	63.00
64.00	Allowable bad debts (see instructions)	102,229	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	66,449	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,780	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,209,172	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)	-27,722	70.93
70.94	HRR adjustment amount (see instructions)	-105,071	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 12:22 pm
	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)	0	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)	0	0	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)		5,076,379	71.00
71.01	Sequestration adjustment (see instructions)		101,528	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		4,843,890	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)		130,961	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		42,661	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (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	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 12:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,890	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,933,027	2.00
3.00	OPPS payments	3,902,667	3.00
4.00	Outlier payment (see instructions)	10,875	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)	1,890	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,809	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)	7,809	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)	7,809	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,919	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)	1,890	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)	3,913,542	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	756,792	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)	3,158,640	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)	3,158,640	30.00
31.00	Primary payer payments	528	31.00
32.00	Subtotal (line 30 minus line 31)	3,158,112	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)	102,533	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	66,646	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	98,367	36.00
37.00	Subtotal (see instructions)	3,224,758	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,224,758	40.00
40.01	Sequestration adjustment (see instructions)	64,495	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,167,742	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-7,479	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

Title XVIII | Hospital | 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		4,843,890		3,167,742	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)		4,843,890		3,167,742	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		130,961		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		7,479	6.02
7.00	Total Medicare program liability (see instructions)		4,974,851		3,160,263	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 12:22 pm
	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 12:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,011,025	0	0	0	1.00
2.00	Temporary investments	328,561	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	40,503,433	0	0	0	4.00
5.00	Other receivable	1,461,798	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-29,925,100	0	0	0	6.00
7.00	Inventory	1,313,032	0	0	0	7.00
8.00	Prepaid expenses	1,851,067	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)	17,543,816	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,250,000	0	0	0	12.00
13.00	Land improvements	180,968	0	0	0	13.00
14.00	Accumulated depreciation	-42,902	0	0	0	14.00
15.00	Buildings	7,037,722	0	0	0	15.00
16.00	Accumulated depreciation	-687,835	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,997,622	0	0	0	19.00
20.00	Accumulated depreciation	-589,904	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	4,925,354	0	0	0	23.00
24.00	Accumulated depreciation	-521,689	0	0	0	24.00
25.00	Minor equipment depreciable	60,688	0	0	0	25.00
26.00	Accumulated depreciation	43,724	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	3,355,931	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,009,679	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,449,088	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	6,432,217	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,881,305	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,434,800	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,693,588	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,165,106	0	0	0	38.00
39.00	Payroll taxes payable	294,087	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,316,661	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	6,761,314	0	0	0	43.00
44.00	Other current liabilities	3,737,371	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,968,127	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	15,814,281	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,814,281	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	35,782,408	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,652,392				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)	12,652,392	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,434,800	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 12:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,119,918		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		37,871				2.00
3.00	Total (sum of line 1 and line 2)		21,157,789		0		3.00
4.00	NI ROUNDING	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)		21,157,789		0		11.00
12.00	TEMPORARILY RESTRICTED	540,288		0		0	12.00
13.00	CHANGE IN NET ASSETS	7,964,527		0		0	13.00
14.00	NI ROUNDING	582		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)		8,505,397		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,652,392		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	NI ROUNDING		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	TEMPORARILY RESTRICTED		0		12.00
13.00	CHANGE IN NET ASSETS		0		13.00
14.00	NI ROUNDING		0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2018 12:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,996,842		7,996,842	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	0		0	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)	7,996,842		7,996,842	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,372,651		1,372,651	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)	1,372,651		1,372,651	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,369,493		9,369,493	17.00
18.00	Ancillary services	26,788,715	85,582,525	112,371,240	18.00
19.00	Outpatient services	3,694,695	25,277,882	28,972,577	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		901,645	901,645	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	520,293	7,592,454	8,112,747	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,373,196	119,354,506	159,727,702	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,893,921		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)		41,893,921		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/29/2018 12:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	159,727,702	1.00
2.00	Less contractual allowances and discounts on patients' accounts	118,817,196	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,910,506	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,893,921	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-983,415	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	210,162	6.00
7.00	Income from investments	307,633	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	34,313	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	42,764	13.00
14.00	Revenue from meals sold to employees and guests	305,281	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	7,138	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	7,330	22.00
23.00	Governmental appropriations	0	23.00
24.00	INVESTMENT INCOME ON SI TRUST	56,321	24.00
24.01	MISCELLANEOUS INCOME	139,558	24.01
25.00	Total other income (sum of lines 6-24)	1,110,500	25.00
26.00	Total (line 5 plus line 25)	127,085	26.00
27.00	UNREALIZED LOSS ON INVESTMENTS	81,014	27.00
27.01	LOSS ON ASSET DISPOSAL	8,200	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	89,214	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	37,871	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/29/2018 12:22 pm

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		8,166	8,166	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3,265	3,265	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	85,483	0	10,940	4,541	18,652	119,616	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	156,496	0	0	0	0	156,496	6.00
7.00	Physical Therapy	0	0	0	109,160	0	109,160	7.00
8.00	Occupational Therapy	0	0	0	49,663	0	49,663	8.00
9.00	Speech Pathology	0	0	0	3,890	0	3,890	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	11,927	0	0	0	0	11,927	11.00
12.00	Supplies (see instructions)	0	0	0	2,995	2,523	5,518	12.00
13.00	Drugs	0	0	0	0	50	50	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)	253,906	0	10,940	170,249	32,656	467,751	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	8,166	0	8,166			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	3,265	0	3,265			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	119,616	0	119,616			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	156,496	0	156,496			6.00
7.00	Physical Therapy	0	109,160	0	109,160			7.00
8.00	Occupational Therapy	0	49,663	0	49,663			8.00
9.00	Speech Pathology	0	3,890	0	3,890			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	11,927	0	11,927			11.00
12.00	Supplies (see instructions)	-2,523	2,995	0	2,995			12.00
13.00	Drugs	20	70	0	70			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)	-2,503	465,248	0	465,248			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: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	8,166	8,166				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	3,265	0	0	3,265		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	119,616	8,166	0	3,265	0	131,047	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	156,496	0	0	0	0	156,496	6.00
7.00	Physical Therapy	109,160	0	0	0	0	109,160	7.00
8.00	Occupational Therapy	49,663	0	0	0	0	49,663	8.00
9.00	Speech Pathology	3,890	0	0	0	0	3,890	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	11,927	0	0	0	0	11,927	11.00
12.00	Supplies (see instructions)	2,995	0	0	0	0	2,995	12.00
13.00	Drugs	70	0	0	0		70	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)	465,248	8,166	0	3,265	0	465,248	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	131,047		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	61,366	217,862	6.00
7.00	Physical Therapy	42,804	151,964	7.00
8.00	Occupational Therapy	19,474	69,137	8.00
9.00	Speech Pathology	1,525	5,415	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	4,677	16,604	11.00
12.00	Supplies (see instructions)	1,174	4,169	12.00
13.00	Drugs	27	97	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)		465,248	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-1 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

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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	2,371				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,371		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	2,371	0	2,371	0	-131,047	334,201	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	156,496	6.00
7.00	Physical Therapy	0	0	0	0	0	109,160	7.00
8.00	Occupational Therapy	0	0	0	0	0	49,663	8.00
9.00	Speech Pathology	0	0	0	0	0	3,890	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11,927	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	2,995	12.00
13.00	Drugs	0	0	0		0	70	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)	2,371	0	2,371	0	-131,047	334,201	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	8,166	0	3,265	0		131,047	25.00
26.00	Unit Cost Multiplier	3.444116	0.000000	1.377056	0.000000		0.392120	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	7,964	6,705	22,524	37,193	13,670	1.00
2.00	Skilled Nursing Care	217,862	0	0	41,234	259,096	95,229	2.00
3.00	Physical Therapy	151,964	0	0	0	151,964	55,853	3.00
4.00	Occupational Therapy	69,137	0	0	0	69,137	25,411	4.00
5.00	Speech Pathology	5,415	0	0	0	5,415	1,990	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	16,604	0	0	3,143	19,747	7,258	7.00
8.00	Supplies (see instructions)	4,169	0	0	0	4,169	1,532	8.00
9.00	Drugs	97	0	0	0	97	36	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)	465,248	7,964	6,705	66,901	546,818	200,979	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

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	28,323	0	10,756	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)	28,323	0	10,756	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: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2018 12:22 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	435	15	0	90,392	0	90,392	1.00
2.00	Skilled Nursing Care	0	0	0	354,325	0	354,325	2.00
3.00	Physical Therapy	0	0	0	207,817	0	207,817	3.00
4.00	Occupational Therapy	0	0	0	94,548	0	94,548	4.00
5.00	Speech Pathology	0	0	0	7,405	0	7,405	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	27,005	0	27,005	7.00
8.00	Supplies (see instructions)	0	0	0	5,701	0	5,701	8.00
9.00	Drugs	0	0	0	133	0	133	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)	435	15	0	787,326	0	787,326	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	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	45,956	400,281					2.00
3.00	Physical Therapy	26,954	234,771					3.00
4.00	Occupational Therapy	12,263	106,811					4.00
5.00	Speech Pathology	960	8,365					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	3,503	30,508					7.00
8.00	Supplies (see instructions)	739	6,440					8.00
9.00	Drugs	17	150					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	90,392	787,326					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.	0.129700						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: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	2,371	5,561	85,483	0	37,193	2,371	1.00
2.00	Skilled Nursing Care	0	0	156,496	0	259,096	0	2.00
3.00	Physical Therapy	0	0	0	0	151,964	0	3.00
4.00	Occupational Therapy	0	0	0	0	69,137	0	4.00
5.00	Speech Pathology	0	0	0	0	5,415	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	11,927	0	19,747	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,169	0	8.00
9.00	Drugs	0	0	0	0	97	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)	2,371	5,561	253,906		546,818	2,371	20.00
21.00	Total cost to be allocated	7,964	6,705	66,901		200,979	28,323	21.00
22.00	Unit cost multiplier	3.358920	1.205718	0.263487		0.367543	11.945593	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,371	0	0	0	3,975	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)	0	2,371	0	0	0	3,975	20.00
21.00	Total cost to be allocated	0	10,756	0	0	0	435	21.00
22.00	Unit cost multiplier	0.000000	4.536482	0.000000	0.000000	0.000000	0.109434	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	50	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	50	0			20.00
21.00	Total cost to be allocated	15	0			21.00
22.00	Unit cost multiplier	0.300000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/29/2018 12:22 pm

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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	400,281		400,281	1,678	238.55	1.00
2.00	Physical Therapy	3.00	234,771	0	234,771	1,791	131.08	2.00
3.00	Occupational Therapy	4.00	106,811	0	106,811	696	153.46	3.00
4.00	Speech Pathology	5.00	8,365	0	8,365	33	253.48	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	30,508		30,508	317	96.24	6.00
7.00	Total (sum of lines 1-6)		780,736	0	780,736	4,515		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		37900	0	964			8.00
8.01	Skilled Nursing Care		99914	0	70			8.01
9.00	Physical Therapy		37900	0	1,100			9.00
9.01	Physical Therapy		99914	0	102			9.01
10.00	Occupational Therapy		37900	0	534			10.00
10.01	Occupational Therapy		99914	0	47			10.01
11.00	Speech Pathology		37900	0	45			11.00
11.01	Speech Pathology		99914	0	0			11.01
12.00	Medical Social Services		37900	0	0			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		37900	0	199			13.00
13.01	Home Health Aide		99914	0	29			13.01
14.00	Total (sum of lines 8-13)			0	3,090			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	6,440	0	6,440	1,724	3.735499	15.00
16.00	Cost of Drugs	9.00	150	0	150	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	1,034		0	246,661		1.00
2.00	Physical Therapy	0	1,202		0	157,558		2.00
3.00	Occupational Therapy	0	581		0	89,160		3.00
4.00	Speech Pathology	0	45		0	11,407		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	228		0	21,943		6.00
7.00	Total (sum of lines 1-6)	0	3,090		0	526,729		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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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	1,724	0	0	6,440	0	15.00
16.00	Cost of Drugs	0	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	246,661						1.00
2.00	Physical Therapy	157,558						2.00
3.00	Occupational Therapy	89,160						3.00
4.00	Speech Pathology	11,407						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	21,943						6.00
7.00	Total (sum of lines 1-6)	526,729						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: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-3 Part II | Date/Time Prepared: 5/29/2018 12:22 pm

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	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	0.315515	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.270641	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.409815	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.766742	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.241379	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2018 12:22 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	484,684	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	32,394	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	4,140	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	5,935	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	4,725	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	107	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	531,985	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	531,985	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	531,985	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	531,985	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	531,985	31.00
31.01	Sequestration adjustment (see instructions)	0	10,640	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	521,345	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: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/29/2018 12:22 pm

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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		0		521,345	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		521,345	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		521,345	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0120	Period: From 05/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/29/2018 12:22 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	396,939	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,071	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)	25.47	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)	2.87	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.59	8.00
9.00	Sum of lines 7 and 8	22.46	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.66	10.00
11.00	Disproportionate share adjustment (see instructions)	18,497	11.00
12.00	Total prospective capital payments (see instructions)	418,507	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