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: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 7:44 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 7:44 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PROCTOR HOSPITAL (14-0013) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] 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)

VICE PRESIDENT OF FINANCE
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	34,257	31,787	0	0	1.00
2.00	Subprovider - IPF	0	7	-178		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	34,264	31,609	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 7:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	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	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P	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	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	773	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 7:44 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 7:44 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 7:44 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			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		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 7:44 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	689,044	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 7:44 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PEORIA HOME OFFICE	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 221 NE GLEN OAK	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61636	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.	N	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	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)	10/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2019 7:44 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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.			Y	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	04/19/2019	Y	04/19/2019 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

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		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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEITH	LYONS	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-672-4281	KEITH.LYONS@UNITYPOINT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 7:44 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST		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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 7:44 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	93	34,310	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)		93	34,310	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	16	5,840	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)		109	40,150	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	43	15,695		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)		170				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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 7:44 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,419	707	12,241			1.00
2.00	HMO and other (see instructions)	3,156	0				2.00
3.00	HMO IPF Subprovider	49	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)	6,419	707	12,241			7.00
8.00	INTENSIVE CARE UNIT	869	66	1,611			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	7,288	773	13,852	0.00	519.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,529	0	3,682	0.00	28.40	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	5,874	0	9,444	0.00	41.70	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	589.70	27.00
28.00	Observation Bed Days		200	2,333			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			35			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 7:44 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,781	177	3,467	1.00
2.00	HMO and other (see instructions)			708	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	1,781	177	3,467	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	175	0	260	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2019 7:44 am

		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	29,864,807	0	29,864,807	1,205,941.00	24.76	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		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,913,811	-973,699	940,112	42,315.00	22.22	9.00
10.00	Excluded area salaries (see instructions)		3,475,778	257,677	3,733,455	178,814.00	20.88	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,538,900	0	2,538,900	64,362.00	39.45	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		12,272	0	12,272	199.00	61.67	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		7,669,289	0	7,669,289	216,402.00	35.44	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)		9,665,560	0	9,665,560			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,179,737	0	2,179,737			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		36,285	0	36,285			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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	108,823	-108,823	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	881,902	108,823	990,725	53,333.00	18.58	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2019 7:44 am

		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	
28.00	Administrative & General under contract (see inst.)		260,379	0	260,379	1,026.00	253.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,045,907	0	1,045,907	45,534.00	22.97	30.00
31.00	Laundry & Linen Service	8.00	27,364	0	27,364	2,311.00	11.84	31.00
32.00	Housekeeping	9.00	895,554	0	895,554	63,813.00	14.03	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	918,594	-669,139	249,455	15,151.00	16.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	411,462	411,462	28,092.00	14.65	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	306,210	0	306,210	11,607.00	26.38	38.00
39.00	Central Services and Supply	14.00	416,873	0	416,873	25,424.00	16.40	39.00
40.00	Pharmacy	15.00	1,016,477	0	1,016,477	30,351.00	33.49	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/28/2019 7:44 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		30,125,186	0	30,125,186	1,206,967.00	24.96	1.00
2.00	Excluded area salaries (see instructions)		5,389,589	-716,022	4,673,567	221,129.00	21.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,735,597	716,022	25,451,619	985,838.00	25.82	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,220,461	0	10,220,461	280,963.00	36.38	4.00
5.00	Subtotal wage-related costs (see inst.)		9,665,560	0	9,665,560	0.00	37.98	5.00
6.00	Total (sum of lines 3 thru 5)		44,621,618	716,022	45,337,640	1,266,801.00	35.79	6.00
7.00	Total overhead cost (see instructions)		5,878,083	-257,677	5,620,406	276,642.00	20.32	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/28/2019 7:44 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,138,243	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)	4,343,859	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,488,526	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	86,081	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,365	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)	10,497	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	395,045	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,168,897	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	69,965	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	35,701	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,764,179	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	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	0	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	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 7:44 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	417	0	417	12.00
13.00		RUB	1,810	0	1,810	13.00
14.00		RUA	1,954	0	1,954	14.00
15.00		RVC	220	0	220	15.00
16.00		RVB	557	0	557	16.00
17.00		RVA	570	0	570	17.00
18.00		RHC	41	0	41	18.00
19.00		RHB	76	0	76	19.00
20.00		RHA	47	0	47	20.00
21.00		RMC	19	0	19	21.00
22.00		RMB	5	0	5	22.00
23.00		RMA	11	0	11	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	5	0	5	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	14	0	14	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	3	0	3	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	12	0	12	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	7	0	7	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	4	0	4	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	9	0	9	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	2	0	2	48.00
49.00		CC2	8	0	8	49.00
50.00		CC1	22	0	22	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	13	0	13	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	2	0	2	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 7:44 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	7	0	7	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	8	0	8	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	11	0	11	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	11	0	11	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	9	0	9	199.00
200.00	TOTAL		5,874	0	5,874	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	17,201,065			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/28/2019 7:44 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.165873	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,330,842	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	46,851,528	6.00
7.00	Medicaid cost (line 1 times line 6)	7,771,404	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,440,562	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,440,562	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)	1,835,406	1,481,887	3,317,293	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	304,444	1,481,887	1,786,331	21.00
22.00	Payments received from patients for amounts previously written off as charity care	41,944	33,214	75,158	22.00
23.00	Cost of charity care (line 21 minus line 22)	262,500	1,448,673	1,711,173	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)	5,515,565	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	294,663	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	453,328	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,062,237	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	998,353	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,709,526	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,150,088	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,879,690	1,879,690	677,590	2,557,280	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	68,293	68,293	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	108,823	57,978	166,801	-133,654	33,147	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	881,902	6,503,266	7,385,168	-581,731	6,803,437	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,591,648	1,591,648	0	1,591,648	6.00
7.00	00700	OPERATION OF PLANT	1,045,907	2,558,531	3,604,438	-8	3,604,430	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,364	52,055	79,419	0	79,419	8.00
9.00	00900	HOUSEKEEPING	895,554	642,980	1,538,534	-601	1,537,933	9.00
10.00	01000	DIETARY	918,594	891,055	1,809,649	-1,364,675	444,974	10.00
11.00	01100	CAFETERIA	0	0	0	835,640	835,640	11.00
13.00	01300	NURSING ADMINISTRATION	306,210	69,418	375,628	-54,808	320,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	416,873	801,532	1,218,405	-170,498	1,047,907	14.00
15.00	01500	PHARMACY	1,016,477	3,353,445	4,369,922	-3,075,584	1,294,338	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,800,789	3,241,314	9,042,103	-2,940,959	6,101,144	30.00
31.00	03100	INTENSIVE CARE UNIT	1,008,227	476,378	1,484,605	-105,085	1,379,520	31.00
40.00	04000	SUBPROVIDER - IPF	1,236,999	897,858	2,134,857	-15,552	2,119,305	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,913,811	1,627,978	3,541,789	-1,849,341	1,692,448	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,230,403	15,308,792	17,539,195	-12,547,995	4,991,200	50.00
51.00	05100	RECOVERY ROOM	1,530,400	569,182	2,099,582	-134,515	1,965,067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	61,037	421,521	482,558	-209,804	272,754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,673,280	1,292,764	2,966,044	-351,695	2,614,349	54.00
57.00	05700	CT SCAN	378,470	448,638	827,108	-95,974	731,134	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	358,255	1,170,472	1,528,727	-44,839	1,483,888	58.00
60.00	06000	LABORATORY	1,408,359	2,281,823	3,690,182	-652,096	3,038,086	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	482,464	482,464	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,185,240	1,185,240	64.00
65.00	06500	RESPIRATORY THERAPY	601,909	272,715	874,624	92,255	966,879	65.00
66.00	06600	PHYSICAL THERAPY	0	600,006	600,006	1,017,682	1,617,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	593,654	593,654	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	140,934	140,934	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,692	28,627	115,319	-1,475	113,844	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,851,054	5,851,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,732,484	9,732,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,281,837	3,281,837	73.00
74.00	07400	RENAL DIALYSIS	82,129	201,741	283,870	-78,899	204,971	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	45,895	45,895	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	126,144	327,942	454,086	-113,414	340,672	76.02
76.03	03140	CARDIOLOGY	658,800	895,918	1,554,718	-509,706	1,045,012	76.03
76.97	07697	CARDIAC REHABILITATION	402,164	137,873	540,037	-91,040	448,997	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	597,789	989,348	1,587,137	1,814,254	3,401,391	90.00
91.00	09100	EMERGENCY	1,852,667	1,701,383	3,554,050	-1,218,646	2,335,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,626,028	51,293,871	78,919,899	-523,318	78,396,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	432,199	432,199	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	674,892	345,986	1,020,878	91,119	1,111,997	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	600,289	571,190	1,171,479	0	1,171,479	194.09
194.10	07960	ARC INGALLS	963,598	414,883	1,378,481	0	1,378,481	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	29,864,807	52,625,930	82,490,737	0	82,490,737	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-148,388	2,408,892		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	68,293		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,177,440	-1,144,293		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,258,874	19,062,311		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,591,648		6.00
7.00	00700	OPERATION OF PLANT	33,327	3,637,757		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-7,476	71,943		8.00
9.00	00900	HOUSEKEEPING	0	1,537,933		9.00
10.00	01000	DIETARY	0	444,974		10.00
11.00	01100	CAFETERIA	0	835,640		11.00
13.00	01300	NURSING ADMINISTRATION	1,573,449	1,894,269		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,047,907		14.00
15.00	01500	PHARMACY	0	1,294,338		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,023,030	1,023,030		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-291,915	5,809,229		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,379,520		31.00
40.00	04000	SUBPROVIDER - IPF	-199,938	1,919,367		40.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,692,448		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-277,500	4,713,700		50.00
51.00	05100	RECOVERY ROOM	0	1,965,067		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-500	272,254		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-79,648	2,534,701		54.00
57.00	05700	CT SCAN	0	731,134		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,483,888		58.00
60.00	06000	LABORATORY	-75,451	2,962,635		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	482,464		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,185,240		64.00
65.00	06500	RESPIRATORY THERAPY	0	966,879		65.00
66.00	06600	PHYSICAL THERAPY	0	1,617,688		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	593,654		67.00
68.00	06800	SPEECH PATHOLOGY	0	140,934		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	113,844		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,851,054		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,732,484		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,281,837		73.00
74.00	07400	RENAL DIALYSIS	0	204,971		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	45,895		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	340,672		76.02
76.03	03140	CARDIOLOGY	-5,951	1,039,061		76.03
76.97	07697	CARDIAC REHABILITATION	-43,961	405,036		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-79,128	3,322,263		90.00
91.00	09100	EMERGENCY	-678,236	1,657,168		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,823,148	90,219,729		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	0		194.01
194.02	07952	MARKETING	0	0		194.02
194.03	07953	GUEST MEALS	0	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	432,199		194.04
194.05	07955	FOUNDATION	0	0		194.05
194.06	07956	DAYCARE CENTER	0	1,111,997		194.06
194.07	07957	UN-USED SQR FT - POB	0	0		194.07
194.08	07958	SENIOR SERVICES	0	0		194.08
194.09	07959	ARC BROMENN	0	1,171,479		194.09
194.10	07960	ARC INGALLS	0	1,378,481		194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	11,823,148	94,313,885		200.00

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 7:44 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	411,462	424,178		1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	212,811	219,388		2.00
3.00	DAYCARE CENTER	194.06	44,866	46,253		3.00
	0		669,139	689,819		
	F - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,281,837		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	142		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
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
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
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
	0		0	3,281,979		
	G - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,851,054		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
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
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	5,851,054		
	I - IMPLANTIBLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,732,484		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
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
	0		0	9,732,484		

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 7:44 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - BLOOD RECLASS					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	319,843		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	319,843		
	K - COST CENTER MAPPING					
1.00	OPERATING ROOM	50.00	234,086	94,160		1.00
2.00	ANESTHESIOLOGY	53.00	13,077	11,977		2.00
3.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	79,058	83,563		3.00
4.00	INTRAVENOUS THERAPY	64.00	723,447	461,793		4.00
5.00	RESPIRATORY THERAPY	65.00	142,419	135,744		5.00
6.00	PHYSICAL THERAPY	66.00	662,372	530,071		6.00
7.00	OCCUPATIONAL THERAPY	67.00	271,296	322,358		7.00
8.00	SPEECH PATHOLOGY	68.00	40,032	100,902		8.00
9.00	PULMONARY FUNCTION TESTING	76.01	35,459	10,436		9.00
10.00	CARDIOLOGY	76.03	429,183	256,747		10.00
11.00	CLINIC	90.00	1,427,409	842,447		11.00
12.00	ADMINISTRATIVE & GENERAL	5.00	108,823	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
	0		4,166,661	2,850,198		
	M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	677,590		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	68,293		2.00
3.00		0.00	0	0		3.00
	0		0	745,883		
500.00	Grand Total: Increases		4,835,800	23,471,260		500.00

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 7:44 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	669,139	689,819	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		669,139	689,819			
	F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,452	0		1.00
2.00	DIETARY	10.00	0	5,717	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,130	0		3.00
4.00	PHARMACY	15.00	0	3,036,512	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	20,166	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	3,825	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	55	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	3,096	0		8.00
9.00	OPERATING ROOM	50.00	0	42,188	0		9.00
10.00	RECOVERY ROOM	51.00	0	11,261	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	15,824	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,117	0		12.00
13.00	CT SCAN	57.00	0	34,328	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	36,171	0		14.00
15.00	LABORATORY	60.00	0	25	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	3,823	0		16.00
17.00	GASTRO INTESTINAL SERVICES	76.02	0	730	0		17.00
18.00	CARDIOLOGY	76.03	0	2,165	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	34	0		19.00
20.00	CLINIC	90.00	0	19,869	0		20.00
21.00	EMERGENCY	91.00	0	12,362	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	5	0		22.00
23.00	RENAL DIALYSIS	74.00	0	116	0		23.00
24.00	OPERATION OF PLANT	7.00	0	8	0		24.00
	0		0	3,281,979			
	G - MED SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	131,836	0		1.00
2.00	PHARMACY	15.00	0	39,039	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	299,408	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	99,549	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	15,493	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	93,328	0		6.00
7.00	OPERATING ROOM	50.00	0	3,521,417	0		7.00
8.00	RECOVERY ROOM	51.00	0	123,033	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	218,823	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	123,779	0		10.00
11.00	CT SCAN	57.00	0	60,578	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8,668	0		12.00
13.00	LABORATORY	60.00	0	201,782	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	91,743	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	640	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,475	0		16.00
17.00	GASTRO INTESTINAL SERVICES	76.02	0	87,352	0		17.00
18.00	CARDIOLOGY	76.03	0	293,818	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	3,925	0		19.00
20.00	CLINIC	90.00	0	145,693	0		20.00
21.00	EMERGENCY	91.00	0	217,737	0		21.00
22.00	RENAL DIALYSIS	74.00	0	71,938	0		22.00
	0		0	5,851,054			
	I - IMPLANTIBLE RECLASS						
1.00	HOUSEKEEPING	9.00	0	601	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,532	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	346	0		3.00
4.00	OPERATING ROOM	50.00	0	9,245,370	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	211	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,874	0		6.00
7.00	CT SCAN	57.00	0	1,068	0		7.00
8.00	GASTRO INTESTINAL SERVICES	76.02	0	3,681	0		8.00
9.00	CARDIOLOGY	76.03	0	273,306	0		9.00
10.00	CLINIC	90.00	0	140,258	0		10.00
11.00	EMERGENCY	91.00	0	4	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	5	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	4	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	3	0		14.00
15.00	RECOVERY ROOM	51.00	0	221	0		15.00
	0		0	9,732,484			

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 7:44 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - BLOOD RECLASS						
1.00	PHARMACY	15.00	0	33	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44	0		2.00
3.00	LABORATORY	60.00	0	319,766	0		3.00
	0		0	319,843			
	K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	1,684,065	936,974	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	1,428	278	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	973,699	779,215	0		3.00
4.00	OPERATING ROOM	50.00	32,215	35,051	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	146,678	43,203	0		5.00
6.00	LABORATORY	60.00	58,014	72,509	0		6.00
7.00	RESPIRATORY THERAPY	65.00	69,799	20,543	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	174,116	0		8.00
9.00	RENAL DIALYSIS	74.00	2,654	4,191	0		9.00
10.00	GASTRO INTESTINAL SERVICES	76.02	7,538	14,113	0		10.00
11.00	CARDIOLOGY	76.03	410,649	215,698	0		11.00
12.00	CARDIAC REHABILITATION	76.97	65,328	21,753	0		12.00
13.00	CLINIC	90.00	55,208	94,574	0		13.00
14.00	EMERGENCY	91.00	550,563	437,980	0		14.00
15.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	108,823	0	0		15.00
	0		4,166,661	2,850,198			
	M - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	379	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	690,696	9		2.00
3.00	NURSING ADMINISTRATION	13.00	0	54,808	9		3.00
	0		0	745,883			
500.00	Grand Total: Decreases		4,835,800	23,471,260			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2019 7:44 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,081,907	0	0	0	0	1.00
2.00	Land Improvements	6,433,463	0	0	0	0	2.00
3.00	Buildings and Fixtures	67,864,895	802,468	0	802,468	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	20,212,095	498,605	0	498,605	0	5.00
6.00	Movable Equipment	60,420,512	2,006,958	0	2,006,958	809,510	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	161,012,872	3,308,031	0	3,308,031	809,510	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	161,012,872	3,308,031	0	3,308,031	809,510	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,081,907	0	1.00
2.00	Land Improvements	6,433,463	0	2.00
3.00	Buildings and Fixtures	68,667,363	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	20,710,700	0	5.00
6.00	Movable Equipment	61,617,960	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	163,511,393	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	163,511,393	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,879,690	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,879,690	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,879,690	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,879,690	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	101,893,433	0	101,893,433	0.623158	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	61,617,960	0	61,617,960	0.376842	0	2.00
3.00	Total (sum of lines 1-2)	163,511,393	0	163,511,393	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,557,280	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	68,293	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,625,573	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-148,388	0	0	0	2,408,892	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	68,293	2.00
3.00	Total (sum of lines 1-2)	-148,388	0	0	0	2,477,185	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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	-1,774,725			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	15,733,357			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	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
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	PHARMACY - MISC REVENUE	B	0	PHARMACY	15.00	0	33.01
33.03	MISC REVENUE	B	-69,658	OPERATION OF PLANT	7.00	0	33.03
33.04	MISC REVENUE	B	-7,476	LAUNDRY & LINEN SERVICE	8.00	0	33.04
33.08	MISC REVENUE	B	-31,835	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	MISC REVENUE	B	-5,951	CARDIOLOGY	76.03	0	33.09
33.10	MISC REVENUE	B	-580	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.12	MISC REVENUE	B	-26,904	CARDIAC REHABILITATION	76.97	0	33.12
33.14	MISC REVENUE	B	-31,464	EMERGENCY	91.00	0	33.14
33.16	MISC REVENUE	B	-33	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	INTEREST PROPERTY TAXES	A	0	CAP REL COSTS-BLDG & FIXT	1.00	13	33.17
33.18	ADVERTISING A&P	A	-109,745	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	ADVERTISING ER	A	-1,212	EMERGENCY	91.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
33.39	INTEREST EXPENSE	A	-169,824	CAP REL COSTS-BLDG & FIXT	1.00	11	33.39
33.40	POB SECURITY COST	A	-23,076	OPERATION OF PLANT	7.00	0	33.40
33.41	POB SECURITY COST	A	-5,769	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.41
33.42	GRANT EXPENSES	A	0	ADULTS & PEDIATRICS	30.00	0	33.42
33.43	GRANT EXPENSES	A	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.43
33.44	SELF FUNDED INSURANCE	A	-1,651,957	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		11,823,148				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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 7:44 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	480,286	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	1,023,030	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	1,573,449	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	126,061	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	12,258,907	0	4.00
4.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE ALLOCATION	250,188	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	778,905	757,469	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,490,826	757,469	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	UNITY POINT	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: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/28/2019 7:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	480,286	0		1.00
2.00	1,023,030	0		2.00
3.00	1,573,449	0		3.00
3.01	126,061	0		3.01
4.00	12,258,907	0		4.00
4.01	250,188	0		4.01
4.02	21,436	11		4.02
5.00	15,733,357			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	HEALTH SYSTEM		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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 7:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	401,540	397,993	3,547	211,500	10	1.00
2.00	40.00	SUBPROVIDER - IPF	199,938	199,938	0	181,300	0	2.00
3.00	50.00	OPERATING ROOM	277,500	277,500	0	246,400	0	3.00
4.00	53.00	ANESTHESIOLOGY	6,000	500	5,500	239,400	144	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	79,068	79,068	0	271,900	0	5.00
6.00	60.00	LABORATORY	75,451	75,451	0	260,300	0	6.00
7.00	76.97	CARDIAC REHABILITATION	17,057	17,057	0	211,500	0	7.00
8.00	90.00	CLINIC	79,853	79,128	725	211,500	21	8.00
9.00	91.00	EMERGENCY	648,000	645,500	2,500	211,500	24	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,784,407	1,772,135	12,272		199	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	1,017	51	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	16,574	829	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	7.00
8.00	90.00	CLINIC	2,135	107	0	0	0	8.00
9.00	91.00	EMERGENCY	2,440	122	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			22,166	1,109	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	1,017	2,530	400,523		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	199,938		2.00
3.00	50.00	OPERATING ROOM	0	0	0	277,500		3.00
4.00	53.00	ANESTHESIOLOGY	0	16,574	0	500		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	79,068		5.00
6.00	60.00	LABORATORY	0	0	0	75,451		6.00
7.00	76.97	CARDIAC REHABILITATION	0	0	0	17,057		7.00
8.00	90.00	CLINIC	0	2,135	0	79,128		8.00
9.00	91.00	EMERGENCY	0	2,440	60	645,560		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	22,166	2,590	1,774,725		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,408,892	2,408,892				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	68,293		68,293			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,144,293	79,816	2,263	-1,062,214		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,062,311	294,420	8,347	0	19,365,078	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,591,648	375,011	10,631	0	1,977,290	6.00
7.00	00700	OPERATION OF PLANT	3,637,757	26,699	757	0	3,665,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,943	21,634	613	0	94,190	8.00
9.00	00900	HOUSEKEEPING	1,537,933	36,656	1,039	0	1,575,628	9.00
10.00	01000	DIETARY	444,974	30,730	871	0	476,575	10.00
11.00	01100	CAFETERIA	835,640	81,559	2,312	0	919,511	11.00
13.00	01300	NURSING ADMINISTRATION	1,894,269	11,132	316	0	1,905,717	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,047,907	0	0	0	1,047,907	14.00
15.00	01500	PHARMACY	1,294,338	18,530	525	0	1,313,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,023,030	0	0	0	1,023,030	16.00
17.00	01700	SOCIAL SERVICE	0	804	23	0	827	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,809,229	368,878	10,458	0	6,188,565	30.00
31.00	03100	INTENSIVE CARE UNIT	1,379,520	51,155	1,450	0	1,432,125	31.00
40.00	04000	SUBPROVIDER - IPF	1,919,367	39,219	1,112	0	1,959,698	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,692,448	127,148	3,605	0	1,823,201	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,713,700	237,598	6,736	0	4,958,034	50.00
51.00	05100	RECOVERY ROOM	1,965,067	0	0	0	1,965,067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	272,254	3,896	110	0	276,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,534,701	154,066	4,368	0	2,693,135	54.00
57.00	05700	CT SCAN	731,134	0	0	0	731,134	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,483,888	0	0	0	1,483,888	58.00
60.00	06000	LABORATORY	2,962,635	65,480	1,856	0	3,029,971	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	482,464	0	0	0	482,464	63.00
64.00	06400	INTRAVENOUS THERAPY	1,185,240	0	0	0	1,185,240	64.00
65.00	06500	RESPIRATORY THERAPY	966,879	23,877	677	0	991,433	65.00
66.00	06600	PHYSICAL THERAPY	1,617,688	19,806	562	0	1,638,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	593,654	0	0	0	593,654	67.00
68.00	06800	SPEECH PATHOLOGY	140,934	0	0	0	140,934	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,844	49,440	1,402	0	164,686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,851,054	63,400	1,797	0	5,916,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,732,484	0	0	0	9,732,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,281,837	0	0	0	3,281,837	73.00
74.00	07400	RENAL DIALYSIS	204,971	13,279	376	0	218,626	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	45,895	0	0	0	45,895	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	340,672	0	0	0	340,672	76.02
76.03	03140	CARDIOLOGY	1,039,061	0	0	0	1,039,061	76.03
76.97	07697	CARDIAC REHABILITATION	405,036	0	0	0	405,036	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,322,263	54,168	1,536	0	3,377,967	90.00
91.00	09100	EMERGENCY	1,657,168	64,743	1,836	0	1,723,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,219,729	2,313,144	65,578	0	91,183,480	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,490	723	0	26,213	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	432,199	0	0	0	432,199	194.04
194.05	07955	FOUNDATION	0	15,899	451	0	16,350	194.05
194.06	07956	DAYCARE CENTER	1,111,997	51,475	1,459	0	1,164,931	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,884	82	0	2,966	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	1,171,479	0	0	0	1,171,479	194.09
194.10	07960	ARC INGALLS	1,378,481	0	0	0	1,378,481	194.10
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	-1,062,214	-1,062,214	201.00
202.00	TOTAL (sum lines 118 through 201)	94,313,885	2,408,892	68,293	-1,062,214	94,313,885	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	19,365,078					5.00
6.00	00600	MAINTENANCE & REPAIRS	503,748	2,481,038				6.00
7.00	00700	OPERATION OF PLANT	933,775	39,913	4,638,901			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,997	32,340	61,457	211,984		8.00
9.00	00900	HOUSEKEEPING	401,418	54,797	104,132	0	2,135,975	9.00
10.00	01000	DIETARY	121,416	45,939	87,298	0	41,684	10.00
11.00	01100	CAFETERIA	234,261	121,924	231,694	0	110,632	11.00
13.00	01300	NURSING ADMINISTRATION	485,514	16,641	31,623	0	15,100	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	266,972	0	0	0	0	14.00
15.00	01500	PHARMACY	334,609	27,701	52,641	0	25,136	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,634	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	211	1,202	2,284	0	1,091	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,576,642	551,445	1,047,915	96,185	500,370	30.00
31.00	03100	INTENSIVE CARE UNIT	364,858	76,472	145,322	12,659	69,390	31.00
40.00	04000	SUBPROVIDER - IPF	499,266	58,630	111,415	28,932	53,200	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	464,491	190,076	361,204	74,208	172,472	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,263,143	355,190	674,973	0	322,295	50.00
51.00	05100	RECOVERY ROOM	500,634	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	70,382	5,824	11,068	0	5,285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	686,122	230,317	437,673	0	208,986	54.00
57.00	05700	CT SCAN	186,269	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	378,046	0	0	0	0	58.00
60.00	06000	LABORATORY	771,937	97,887	186,016	0	88,821	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	122,916	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	301,960	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	252,584	35,694	67,829	0	32,388	65.00
66.00	06600	PHYSICAL THERAPY	417,323	29,609	56,266	0	26,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,243	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,905	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,957	73,909	140,450	0	67,064	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,507,266	94,777	180,107	0	86,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,479,494	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	836,104	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	55,699	19,851	37,724	0	18,013	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	11,693	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	86,792	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	264,718	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	103,190	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	860,595	80,977	153,882	0	73,478	90.00
91.00	09100	EMERGENCY	439,154	96,786	183,924	0	87,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,296,938	2,337,901	4,366,897	211,984	2,006,094	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,678	38,106	72,413	0	34,577	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	110,110	0	0	0	0	194.04
194.05	07955	FOUNDATION	4,165	23,768	45,166	0	21,567	194.05
194.06	07956	DAYCARE CENTER	296,786	76,951	146,232	0	69,825	194.06
194.07	07957	UN-USED SQR FT - POB	756	4,312	8,193	0	3,912	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	298,454	0	0	0	0	194.09
194.10	07960	ARC INGALLS	351,191	0	0	0	0	194.10
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)	19,365,078	2,481,038	4,638,901	211,984	2,135,975	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	772,912					10.00
11.00	01100	CAFETERIA	0	1,618,022				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,454,595			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,005	0	1,340,884		14.00
15.00	01500	PHARMACY	0	63,408	0	0	1,816,888	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	350,701	256,802	678,055	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	46,155	62,804	165,826	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	105,488	77,164	203,741	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	270,568	58,644	154,842	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	151,725	400,610	0	0	50.00
51.00	05100	RECOVERY ROOM	0	95,466	252,066	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,623	12,207	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,229	251,441	0	0	54.00
57.00	05700	CT SCAN	0	23,609	62,336	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,348	59,007	0	0	58.00
60.00	06000	LABORATORY	0	84,235	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	4,932	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	45,129	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	42,077	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	41,319	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,923	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,497	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,408	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	503,479	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	837,405	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,816,888	73.00
74.00	07400	RENAL DIALYSIS	0	4,958	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	2,212	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	7,399	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	42,252	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	21,012	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	122,888	0	0	0	90.00
91.00	09100	EMERGENCY	0	81,225	214,464	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	772,912	1,462,293	2,454,595	1,340,884	1,816,888	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	13,275	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	44,899	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	37,446	0	0	0	194.09
194.10	07960	ARC INGALLS	0	60,109	0	0	0	194.10
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)	772,912	1,618,022	2,454,595	1,340,884	1,816,888	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,283,664					16.00
17.00	01700	SOCIAL SERVICE	0	5,615				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,265	2,548	11,333,493	0	11,333,493	30.00
31.00	03100	INTENSIVE CARE UNIT	18,155	335	2,394,101	0	2,394,101	31.00
40.00	04000	SUBPROVIDER - IPF	20,006	766	3,118,306	0	3,118,306	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	19,968	1,966	3,591,640	0	3,591,640	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,645	0	8,382,615	0	8,382,615	50.00
51.00	05100	RECOVERY ROOM	57,717	0	2,870,950	0	2,870,950	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	76,519	0	462,168	0	462,168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,872	0	4,656,775	0	4,656,775	54.00
57.00	05700	CT SCAN	83,450	0	1,086,798	0	1,086,798	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	44,992	0	1,988,281	0	1,988,281	58.00
60.00	06000	LABORATORY	87,389	0	4,346,256	0	4,346,256	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,735	0	615,047	0	615,047	63.00
64.00	06400	INTRAVENOUS THERAPY	26,147	0	1,558,476	0	1,558,476	64.00
65.00	06500	RESPIRATORY THERAPY	30,777	0	1,452,782	0	1,452,782	65.00
66.00	06600	PHYSICAL THERAPY	19,591	0	2,229,031	0	2,229,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,206	0	769,026	0	769,026	67.00
68.00	06800	SPEECH PATHOLOGY	1,744	0	181,080	0	181,080	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	965	0	494,439	0	494,439	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	82,061	0	8,369,941	0	8,369,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,976	0	13,123,359	0	13,123,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,655	0	6,007,484	0	6,007,484	73.00
74.00	07400	RENAL DIALYSIS	402	0	355,273	0	355,273	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,639	0	62,439	0	62,439	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	14,699	0	449,562	0	449,562	76.02
76.03	03140	CARDIOLOGY	38,438	0	1,384,469	0	1,384,469	76.03
76.97	07697	CARDIAC REHABILITATION	3,099	0	532,337	0	532,337	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	42,870	0	4,712,657	0	4,712,657	90.00
91.00	09100	EMERGENCY	58,682	0	2,885,804	0	2,885,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,283,664	5,615	89,414,589	0	89,414,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	177,987	0	177,987	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	13,275	0	13,275	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	542,309	0	542,309	194.04
194.05	07955	FOUNDATION	0	0	111,016	0	111,016	194.05
194.06	07956	DAYCARE CENTER	0	0	1,799,624	0	1,799,624	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	20,139	0	20,139	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,507,379	0	1,507,379	194.09
194.10	07960	ARC INGALLS	0	0	1,789,781	0	1,789,781	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	-1,062,214	0	-1,062,214	201.00
202.00		TOTAL (sum lines 118 through 201)	1,283,664	5,615	94,313,885	0	94,313,885	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,171	79,816	2,263	88,250	88,250	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,324	294,420	8,347	337,091	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	332,553	375,011	10,631	718,195	0	6.00
7.00	00700	OPERATION OF PLANT	89,224	26,699	757	116,680	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,634	613	22,247	0	8.00
9.00	00900	HOUSEKEEPING	11,774	36,656	1,039	49,469	0	9.00
10.00	01000	DIETARY	37,445	30,730	871	69,046	0	10.00
11.00	01100	CAFETERIA	0	81,559	2,312	83,871	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,132	316	11,448	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	263,761	0	0	263,761	0	14.00
15.00	01500	PHARMACY	52,520	18,530	525	71,575	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	804	23	827	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,902	368,878	10,458	489,238	0	30.00
31.00	03100	INTENSIVE CARE UNIT	51,683	51,155	1,450	104,288	0	31.00
40.00	04000	SUBPROVIDER - IPF	83,097	39,219	1,112	123,428	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	72,075	127,148	3,605	202,828	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	897,083	237,598	6,736	1,141,417	0	50.00
51.00	05100	RECOVERY ROOM	14,158	0	0	14,158	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	164,177	3,896	110	168,183	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,255	154,066	4,368	462,689	0	54.00
57.00	05700	CT SCAN	239,659	0	0	239,659	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	775,036	0	0	775,036	0	58.00
60.00	06000	LABORATORY	127,919	65,480	1,856	195,255	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	11,410	0	0	11,410	0	63.00
64.00	06400	INTRAVENOUS THERAPY	54,225	0	0	54,225	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,823	23,877	677	60,377	0	65.00
66.00	06600	PHYSICAL THERAPY	52,430	19,806	562	72,798	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,311	0	0	21,311	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,342	0	0	3,342	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,971	49,440	1,402	55,813	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	63,400	1,797	65,197	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
74.00	07400	RENAL DIALYSIS	95,040	13,279	376	108,695	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,932	0	0	1,932	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	190,518	0	0	190,518	0	76.02
76.03	03140	CARDIOLOGY	129,492	0	0	129,492	0	76.03
76.97	07697	CARDIAC REHABILITATION	24,244	0	0	24,244	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	164,024	54,168	1,536	219,728	0	90.00
91.00	09100	EMERGENCY	119,450	64,743	1,836	186,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,575,028	2,313,144	65,578	6,953,750	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,490	723	26,213	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	15,899	451	16,350	0	194.05
194.06	07956	DAYCARE CENTER	881	51,475	1,459	53,815	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,884	82	2,966	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	88,250	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	4,575,909	2,408,892	68,293	7,053,094	88,250	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	337,091					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,769	726,964				6.00
7.00	00700	OPERATION OF PLANT	16,255	11,695	144,630			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	418	9,476	1,916	34,057		8.00
9.00	00900	HOUSEKEEPING	6,988	16,056	3,247	0	75,760	9.00
10.00	01000	DIETARY	2,114	13,460	2,722	0	1,478	10.00
11.00	01100	CAFETERIA	4,078	35,725	7,224	0	3,924	11.00
13.00	01300	NURSING ADMINISTRATION	8,452	4,876	986	0	536	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,647	0	0	0	0	14.00
15.00	01500	PHARMACY	5,825	8,117	1,641	0	892	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,537	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4	352	71	0	39	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,446	161,575	32,671	15,453	17,748	30.00
31.00	03100	INTENSIVE CARE UNIT	6,351	22,407	4,531	2,034	2,461	31.00
40.00	04000	SUBPROVIDER - IPF	8,691	17,179	3,474	4,648	1,887	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,086	55,694	11,261	11,922	6,117	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,989	104,074	21,044	0	11,431	50.00
51.00	05100	RECOVERY ROOM	8,715	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,225	1,707	345	0	187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,944	67,485	13,646	0	7,412	54.00
57.00	05700	CT SCAN	3,243	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,581	0	0	0	0	58.00
60.00	06000	LABORATORY	13,438	28,682	5,800	0	3,150	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,140	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	5,257	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,397	10,459	2,115	0	1,149	65.00
66.00	06600	PHYSICAL THERAPY	7,265	8,676	1,754	0	953	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,633	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	625	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	730	21,656	4,379	0	2,379	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,239	27,771	5,615	0	3,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,144	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,555	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	970	5,817	1,176	0	639	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	204	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,511	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	4,608	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,796	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,981	23,727	4,798	0	2,606	90.00
91.00	09100	EMERGENCY	7,645	28,359	5,734	0	3,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	318,496	685,025	136,150	34,057	71,153	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	116	11,165	2,258	0	1,226	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	1,917	0	0	0	0	194.04
194.05	07955	FOUNDATION	73	6,964	1,408	0	765	194.05
194.06	07956	DAYCARE CENTER	5,166	22,547	4,559	0	2,477	194.06
194.07	07957	UN-USED SQR FT - POB	13	1,263	255	0	139	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	5,196	0	0	0	0	194.09
194.10	07960	ARC INGALLS	6,114	0	0	0	0	194.10
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)	337,091	726,964	144,630	34,057	75,760	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	88,820					10.00
11.00	01100	CAFETERIA	0	134,822				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	26,298			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,167	0	270,575		14.00
15.00	01500	PHARMACY	0	5,284	0	0	93,334	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,301	21,396	7,262	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,304	5,233	1,777	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	12,122	6,430	2,183	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	31,093	4,887	1,659	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,643	4,293	0	0	50.00
51.00	05100	RECOVERY ROOM	0	7,955	2,701	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	385	131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,935	2,694	0	0	54.00
57.00	05700	CT SCAN	0	1,967	668	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,862	632	0	0	58.00
60.00	06000	LABORATORY	0	7,019	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	411	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,760	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,506	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,443	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,410	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	208	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	451	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	101,595	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,980	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	93,334	73.00
74.00	07400	RENAL DIALYSIS	0	413	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	184	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	617	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	3,521	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,751	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,240	0	0	0	90.00
91.00	09100	EMERGENCY	0	6,768	2,298	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,820	121,846	26,298	270,575	93,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,106	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	3,741	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	3,120	0	0	0	194.09
194.10	07960	ARC INGALLS	0	5,009	0	0	0	194.10
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)	88,820	134,822	26,298	270,575	93,334	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	4,537					16.00
17.00	01700	SOCIAL SERVICE	0	1,293				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	283	587	813,960	0	813,960	30.00
31.00	03100	INTENSIVE CARE UNIT	61	77	154,524	0	154,524	31.00
40.00	04000	SUBPROVIDER - IPF	67	176	180,285	0	180,285	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	67	453	334,067	0	334,067	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,088	0	1,317,979	0	1,317,979	50.00
51.00	05100	RECOVERY ROOM	194	0	33,723	0	33,723	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	257	0	172,420	0	172,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	181	0	573,986	0	573,986	54.00
57.00	05700	CT SCAN	280	0	245,817	0	245,817	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	151	0	784,262	0	784,262	58.00
60.00	06000	LABORATORY	294	0	253,638	0	253,638	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	16	0	13,977	0	13,977	63.00
64.00	06400	INTRAVENOUS THERAPY	88	0	63,330	0	63,330	64.00
65.00	06500	RESPIRATORY THERAPY	103	0	82,106	0	82,106	65.00
66.00	06600	PHYSICAL THERAPY	66	0	94,955	0	94,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	24	0	25,378	0	25,378	67.00
68.00	06800	SPEECH PATHOLOGY	6	0	4,181	0	4,181	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3	0	85,411	0	85,411	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	276	0	229,743	0	229,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249	0	212,373	0	212,373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244	0	108,133	0	108,133	73.00
74.00	07400	RENAL DIALYSIS	1	0	117,711	0	117,711	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	9	0	2,329	0	2,329	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	49	0	192,695	0	192,695	76.02
76.03	03140	CARDIOLOGY	129	0	137,750	0	137,750	76.03
76.97	07697	CARDIAC REHABILITATION	10	0	27,801	0	27,801	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	144	0	276,224	0	276,224	90.00
91.00	09100	EMERGENCY	197	0	240,145	0	240,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,537	1,293	6,778,903	0	6,778,903	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40,978	0	40,978	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	1,106	0	1,106	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	1,917	0	1,917	194.04
194.05	07955	FOUNDATION	0	0	25,560	0	25,560	194.05
194.06	07956	DAYCARE CENTER	0	0	92,305	0	92,305	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	4,636	0	4,636	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	8,316	0	8,316	194.09
194.10	07960	ARC INGALLS	0	0	11,123	0	11,123	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	88,250	0	88,250	201.00
202.00		TOTAL (sum lines 118 through 201)	4,537	1,293	7,053,094	0	7,053,094	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	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	428,474					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		428,474				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,197	14,197	29,755,985			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,369	52,369	881,902	-19,365,078	76,011,021	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	0	0	1,977,290	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,045,907	0	3,665,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	27,364	0	94,190	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	895,554	0	1,575,628	9.00
10.00	01000	DIETARY	5,466	5,466	249,455	0	476,575	10.00
11.00	01100	CAFETERIA	14,507	14,507	411,462	0	919,511	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	306,210	0	1,905,717	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	416,873	0	1,047,907	14.00
15.00	01500	PHARMACY	3,296	3,296	1,016,477	0	1,313,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,023,030	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	0	827	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	4,116,724	0	6,188,565	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,006,799	0	1,432,125	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	1,236,999	0	1,959,698	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	22,616	22,616	940,112	0	1,823,201	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	2,432,274	0	4,958,034	50.00
51.00	05100	RECOVERY ROOM	0	0	1,530,400	0	1,965,067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	74,114	0	276,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,526,603	0	2,693,135	54.00
57.00	05700	CT SCAN	0	0	378,470	0	731,134	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	358,255	0	1,483,888	58.00
60.00	06000	LABORATORY	11,647	11,647	1,350,345	0	3,029,971	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	79,058	0	482,464	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	723,447	0	1,185,240	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	674,528	0	991,433	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	662,372	0	1,638,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	271,296	0	593,654	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	40,032	0	140,934	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	86,692	0	164,686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	5,916,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,732,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,281,837	73.00
74.00	07400	RENAL DIALYSIS	2,362	2,362	79,474	0	218,626	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	35,459	0	45,895	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	118,606	0	340,672	76.02
76.03	03140	CARDIOLOGY	0	0	677,334	0	1,039,061	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	336,837	0	405,036	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	1,969,991	0	3,377,967	90.00
91.00	09100	EMERGENCY	11,516	11,516	1,302,104	0	1,723,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	411,443	411,443	27,259,529	-19,365,078	71,818,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	26,213	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	212,811	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	432,199	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	0	16,350	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	719,758	0	1,164,931	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	2,966	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	600,289	0	1,171,479	194.09
194.10	07960	ARC INGALLS	0	0	963,598	0	1,378,481	194.10
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,408,892	68,293	-1,062,214		19,365,078	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.622026	0.159387	0.000000		0.254767	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			88,250		337,091	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002966		0.004435	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	295,204					6.00
7.00	00700	OPERATION OF PLANT	4,749	290,455				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	26,978			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	280,087		9.00
10.00	01000	DIETARY	5,466	5,466	0	5,466	26,978	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	0	1,980	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	12,241	65,613	12,241	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,611	9,099	1,611	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	3,682	6,976	3,682	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	22,616	22,616	9,444	22,616	9,444	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
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
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	0	3,523	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
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	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
74.00	07400	RENAL DIALYSIS	2,362	2,362	0	2,362	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	0	9,635	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	278,173	273,424	26,978	263,056	26,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	2,828	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	2,481,038	4,638,901	211,984	2,135,975	772,912	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	8.404486	15.971152	7.857662	7.626113	28.649715	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	726,964	144,630	34,057	75,760	88,820	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.462582	0.497943	1.262399	0.270487	3.292312	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	25,938,131					11.00
13.00	01300	NURSING ADMINISTRATION	0	14,902,854				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	416,873	0	15,584,028			14.00
15.00	01500	PHARMACY	1,016,477	0	0	3,281,838		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	539,053,839	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,116,724	4,116,724	0	0	35,390,558	30.00
31.00	03100	INTENSIVE CARE UNIT	1,006,799	1,006,799	0	0	7,624,954	31.00
40.00	04000	SUBPROVIDER - IPF	1,236,999	1,236,999	0	0	8,402,556	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	940,112	940,112	0	0	8,386,212	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,432,274	2,432,274	0	0	107,714,376	50.00
51.00	05100	RECOVERY ROOM	1,530,400	1,530,400	0	0	24,240,639	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	74,114	74,114	0	0	32,137,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,526,603	1,526,603	0	0	22,625,790	54.00
57.00	05700	CT SCAN	378,470	378,470	0	0	35,048,289	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	358,255	358,255	0	0	18,896,333	58.00
60.00	06000	LABORATORY	1,350,345	0	0	0	36,702,473	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	79,058	0	0	0	1,988,811	63.00
64.00	06400	INTRAVENOUS THERAPY	723,447	0	0	0	10,981,464	64.00
65.00	06500	RESPIRATORY THERAPY	674,528	0	0	0	12,925,955	65.00
66.00	06600	PHYSICAL THERAPY	662,372	0	0	0	8,228,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	271,296	0	0	0	3,026,590	67.00
68.00	06800	SPEECH PATHOLOGY	40,032	0	0	0	732,369	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,692	0	0	0	405,444	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,851,545	0	34,464,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,732,483	0	31,069,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,281,838	30,514,379	73.00
74.00	07400	RENAL DIALYSIS	79,474	0	0	0	169,026	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	35,459	0	0	0	1,108,240	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	118,606	0	0	0	6,173,469	76.02
76.03	03140	CARDIOLOGY	677,334	0	0	0	16,143,808	76.03
76.97	07697	CARDIAC REHABILITATION	336,837	0	0	0	1,301,531	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,969,991	0	0	0	18,004,855	90.00
91.00	09100	EMERGENCY	1,302,104	1,302,104	0	0	24,646,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,441,675	14,902,854	15,584,028	3,281,838	539,053,839	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	212,811	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	719,758	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	600,289	0	0	0	0	194.09
194.10	07960	ARC INGALLS	963,598	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,618,022	2,454,595	1,340,884	1,816,888	1,283,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.062380	0.164706	0.086042	0.553619	0.002381	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	134,822	26,298	270,575	93,334	4,537	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005198	0.001765	0.017362	0.028440	0.000008	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 7:44 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	26,978		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	12,241		30.00
31.00	03100	INTENSIVE CARE UNIT	1,611		31.00
40.00	04000	SUBPROVIDER - IPF	3,682		40.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	9,444		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	ANCILLARY	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0		76.02
76.03	03140	CARDIOLOGY	0		76.03
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,978		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	07951	MEALS ON WHEELS	0		194.01
194.02	07952	MARKETING	0		194.02
194.03	07953	GUEST MEALS	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0		194.04
194.05	07955	FOUNDATION	0		194.05
194.06	07956	DAYCARE CENTER	0		194.06
194.07	07957	UN-USED SQR FT - POB	0		194.07
194.08	07958	SENIOR SERVICES	0		194.08
194.09	07959	ARC BROMENN	0		194.09
194.10	07960	ARC INGALLS	0		194.10
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)	5,615		202.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	
		17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.208133	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,293	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.047928	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 7:44 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,333,493		11,333,493	2,530	11,336,023	30.00
31.00	03100	INTENSIVE CARE UNIT	2,394,101		2,394,101	0	2,394,101	31.00
40.00	04000	SUBPROVIDER - IPF	3,118,306		3,118,306	0	3,118,306	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,591,640		3,591,640	0	3,591,640	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,382,615		8,382,615	0	8,382,615	50.00
51.00	05100	RECOVERY ROOM	2,870,950		2,870,950	0	2,870,950	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	462,168		462,168	0	462,168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,656,775		4,656,775	0	4,656,775	54.00
57.00	05700	CT SCAN	1,086,798		1,086,798	0	1,086,798	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,988,281		1,988,281	0	1,988,281	58.00
60.00	06000	LABORATORY	4,346,256		4,346,256	0	4,346,256	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	615,047		615,047	0	615,047	63.00
64.00	06400	INTRAVENOUS THERAPY	1,558,476		1,558,476	0	1,558,476	64.00
65.00	06500	RESPIRATORY THERAPY	1,452,782	0	1,452,782	0	1,452,782	65.00
66.00	06600	PHYSICAL THERAPY	2,229,031	0	2,229,031	0	2,229,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	769,026	0	769,026	0	769,026	67.00
68.00	06800	SPEECH PATHOLOGY	181,080	0	181,080	0	181,080	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,439		494,439	0	494,439	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,369,941		8,369,941	0	8,369,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,123,359		13,123,359	0	13,123,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,007,484		6,007,484	0	6,007,484	73.00
74.00	07400	RENAL DIALYSIS	355,273		355,273	0	355,273	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,439		62,439	0	62,439	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	449,562		449,562	0	449,562	76.02
76.03	03140	CARDIOLOGY	1,384,469		1,384,469	0	1,384,469	76.03
76.97	07697	CARDIAC REHABILITATION	532,337		532,337	0	532,337	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,712,657		4,712,657	0	4,712,657	90.00
91.00	09100	EMERGENCY	2,885,804		2,885,804	60	2,885,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,814,677		1,814,677		1,814,677	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	91,229,266	0	91,229,266	2,590	91,231,856	200.00
201.00		Less Observation Beds	1,814,677		1,814,677		1,814,677	201.00
202.00		Total (see instructions)	89,414,589	0	89,414,589	2,590	89,417,179	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 7:44 am

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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	31,793,777		31,793,777			30.00
31.00	03100	INTENSIVE CARE UNIT	7,624,954		7,624,954			31.00
40.00	04000	SUBPROVIDER - IPF	8,402,556		8,402,556			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	8,386,212		8,386,212			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,757,141	89,957,235	107,714,376	0.077823	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,388,704	19,851,935	24,240,639	0.118435	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,692,847	27,444,691	32,137,538	0.014381	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,228,013	17,397,777	22,625,790	0.205817	0.000000	54.00
57.00	05700	CT SCAN	8,573,586	26,474,703	35,048,289	0.031009	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,939,840	16,956,493	18,896,333	0.105220	0.000000	58.00
60.00	06000	LABORATORY	13,829,523	22,872,950	36,702,473	0.118419	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,007,588	981,223	1,988,811	0.309254	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,555,546	8,425,918	10,981,464	0.141919	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,057,244	1,868,711	12,925,955	0.112393	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,554,898	673,133	8,228,031	0.270907	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,974,659	51,931	3,026,590	0.254090	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	653,616	78,753	732,369	0.247252	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,860	285,584	405,444	1.219500	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,419,382	24,045,498	34,464,880	0.242854	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,471,800	19,597,455	31,069,255	0.422391	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,792,844	17,721,535	30,514,379	0.196874	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	169,026	169,026	2.101884	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	324,471	783,769	1,108,240	0.056341	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,538,759	4,634,710	6,173,469	0.072822	0.000000	76.02
76.03	03140	CARDIOLOGY	7,938,278	8,205,530	16,143,808	0.085759	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,301,531	1,301,531	0.409008	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,273,006	16,731,849	18,004,855	0.261744	0.000000	90.00
91.00	09100	EMERGENCY	4,869,316	19,776,698	24,646,014	0.117090	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	595,157	3,001,624	3,596,781	0.504528	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	189,763,577	349,290,262	539,053,839			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	189,763,577	349,290,262	539,053,839			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.077823	50.00
51.00	05100	RECOVERY ROOM	0.118435	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	54.00
57.00	05700	CT SCAN	0.031009	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	58.00
60.00	06000	LABORATORY	0.118419	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	73.00
74.00	07400	RENAL DIALYSIS	2.101884	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	76.02
76.03	03140	CARDIOLOGY	0.085759	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.261744	90.00
91.00	09100	EMERGENCY	0.117093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

		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	11,333,493		11,333,493	2,530	11,336,023	30.00
31.00	03100	INTENSIVE CARE UNIT	2,394,101		2,394,101	0	2,394,101	31.00
40.00	04000	SUBPROVIDER - IPF	3,118,306		3,118,306	0	3,118,306	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,591,640		3,591,640	0	3,591,640	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,382,615		8,382,615	0	8,382,615	50.00
51.00	05100	RECOVERY ROOM	2,870,950		2,870,950	0	2,870,950	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	462,168		462,168	0	462,168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,656,775		4,656,775	0	4,656,775	54.00
57.00	05700	CT SCAN	1,086,798		1,086,798	0	1,086,798	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,988,281		1,988,281	0	1,988,281	58.00
60.00	06000	LABORATORY	4,346,256		4,346,256	0	4,346,256	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	615,047		615,047	0	615,047	63.00
64.00	06400	INTRAVENOUS THERAPY	1,558,476		1,558,476	0	1,558,476	64.00
65.00	06500	RESPIRATORY THERAPY	1,452,782	0	1,452,782	0	1,452,782	65.00
66.00	06600	PHYSICAL THERAPY	2,229,031	0	2,229,031	0	2,229,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	769,026	0	769,026	0	769,026	67.00
68.00	06800	SPEECH PATHOLOGY	181,080	0	181,080	0	181,080	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,439		494,439	0	494,439	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,369,941		8,369,941	0	8,369,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,123,359		13,123,359	0	13,123,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,007,484		6,007,484	0	6,007,484	73.00
74.00	07400	RENAL DIALYSIS	355,273		355,273	0	355,273	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,439		62,439	0	62,439	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	449,562		449,562	0	449,562	76.02
76.03	03140	CARDIOLOGY	1,384,469		1,384,469	0	1,384,469	76.03
76.97	07697	CARDIAC REHABILITATION	532,337		532,337	0	532,337	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,712,657		4,712,657	0	4,712,657	90.00
91.00	09100	EMERGENCY	2,885,804		2,885,804	60	2,885,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,814,677		1,814,677		1,814,677	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	91,229,266	0	91,229,266	2,590	91,231,856	200.00
201.00		Less Observation Beds	1,814,677		1,814,677		1,814,677	201.00
202.00		Total (see instructions)	89,414,589	0	89,414,589	2,590	89,417,179	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

		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	31,793,777		31,793,777			30.00
31.00	03100	INTENSIVE CARE UNIT	7,624,954		7,624,954			31.00
40.00	04000	SUBPROVIDER - IPF	8,402,556		8,402,556			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	8,386,212		8,386,212			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,757,141	89,957,235	107,714,376	0.077823	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,388,704	19,851,935	24,240,639	0.118435	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,692,847	27,444,691	32,137,538	0.014381	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,228,013	17,397,777	22,625,790	0.205817	0.000000	54.00
57.00	05700	CT SCAN	8,573,586	26,474,703	35,048,289	0.031009	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,939,840	16,956,493	18,896,333	0.105220	0.000000	58.00
60.00	06000	LABORATORY	13,829,523	22,872,950	36,702,473	0.118419	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,007,588	981,223	1,988,811	0.309254	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,555,546	8,425,918	10,981,464	0.141919	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,057,244	1,868,711	12,925,955	0.112393	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,554,898	673,133	8,228,031	0.270907	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,974,659	51,931	3,026,590	0.254090	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	653,616	78,753	732,369	0.247252	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,860	285,584	405,444	1.219500	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,419,382	24,045,498	34,464,880	0.242854	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,471,800	19,597,455	31,069,255	0.422391	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,792,844	17,721,535	30,514,379	0.196874	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	169,026	169,026	2.101884	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	324,471	783,769	1,108,240	0.056341	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,538,759	4,634,710	6,173,469	0.072822	0.000000	76.02
76.03	03140	CARDIOLOGY	7,938,278	8,205,530	16,143,808	0.085759	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,301,531	1,301,531	0.409008	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,273,006	16,731,849	18,004,855	0.261744	0.000000	90.00
91.00	09100	EMERGENCY	4,869,316	19,776,698	24,646,014	0.117090	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	595,157	3,001,624	3,596,781	0.504528	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	189,763,577	349,290,262	539,053,839			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	189,763,577	349,290,262	539,053,839			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 7:44 am

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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
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.077823	50.00
51.00	05100	RECOVERY ROOM	0.118435	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	54.00
57.00	05700	CT SCAN	0.031009	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	58.00
60.00	06000	LABORATORY	0.118419	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	73.00
74.00	07400	RENAL DIALYSIS	2.101884	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	76.02
76.03	03140	CARDIOLOGY	0.085759	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.261744	90.00
91.00	09100	EMERGENCY	0.117093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,382,615	1,317,979	7,064,636	0	0	50.00
51.00	05100	RECOVERY ROOM	2,870,950	33,723	2,837,227	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	462,168	172,420	289,748	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,656,775	573,986	4,082,789	0	0	54.00
57.00	05700	CT SCAN	1,086,798	245,817	840,981	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,988,281	784,262	1,204,019	0	0	58.00
60.00	06000	LABORATORY	4,346,256	253,638	4,092,618	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	615,047	13,977	601,070	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,558,476	63,330	1,495,146	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,452,782	82,106	1,370,676	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,229,031	94,955	2,134,076	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	769,026	25,378	743,648	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	181,080	4,181	176,899	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,439	85,411	409,028	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,369,941	229,743	8,140,198	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,123,359	212,373	12,910,986	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,007,484	108,133	5,899,351	0	0	73.00
74.00	07400	RENAL DIALYSIS	355,273	117,711	237,562	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,439	2,329	60,110	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	449,562	192,695	256,867	0	0	76.02
76.03	03140	CARDIOLOGY	1,384,469	137,750	1,246,719	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	532,337	27,801	504,536	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,712,657	276,224	4,436,433	0	0	90.00
91.00	09100	EMERGENCY	2,885,804	240,145	2,645,659	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,814,677	130,299	1,684,378	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	70,791,726	5,426,366	65,365,360	0	0	200.00
201.00		Less Observation Beds	1,814,677	130,299	1,684,378	0	0	201.00
202.00		Total (line 200 minus line 201)	68,977,049	5,296,067	63,680,982	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,382,615	107,714,376	0.077823		50.00
51.00	05100	RECOVERY ROOM	2,870,950	24,240,639	0.118435		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	462,168	32,137,538	0.014381		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,656,775	22,625,790	0.205817		54.00
57.00	05700	CT SCAN	1,086,798	35,048,289	0.031009		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,988,281	18,896,333	0.105220		58.00
60.00	06000	LABORATORY	4,346,256	36,702,473	0.118419		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	615,047	1,988,811	0.309254		63.00
64.00	06400	INTRAVENOUS THERAPY	1,558,476	10,981,464	0.141919		64.00
65.00	06500	RESPIRATORY THERAPY	1,452,782	12,925,955	0.112393		65.00
66.00	06600	PHYSICAL THERAPY	2,229,031	8,228,031	0.270907		66.00
67.00	06700	OCCUPATIONAL THERAPY	769,026	3,026,590	0.254090		67.00
68.00	06800	SPEECH PATHOLOGY	181,080	732,369	0.247252		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,439	405,444	1.219500		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,369,941	34,464,880	0.242854		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,123,359	31,069,255	0.422391		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,007,484	30,514,379	0.196874		73.00
74.00	07400	RENAL DIALYSIS	355,273	169,026	2.101884		74.00
76.00	03950	ANCILLARY	0	0	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,439	1,108,240	0.056341		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	449,562	6,173,469	0.072822		76.02
76.03	03140	CARDIOLOGY	1,384,469	16,143,808	0.085759		76.03
76.97	07697	CARDIAC REHABILITATION	532,337	1,301,531	0.409008		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4,712,657	18,004,855	0.261744		90.00
91.00	09100	EMERGENCY	2,885,804	24,646,014	0.117090		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,814,677	3,596,781	0.504528		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	70,791,726	482,846,340			200.00
201.00		Less Observation Beds	1,814,677	0			201.00
202.00		Total (line 200 minus line 201)	68,977,049	482,846,340			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	813,960	0	813,960	14,574	55.85	30.00
31.00	INTENSIVE CARE UNIT	154,524		154,524	1,611	95.92	31.00
40.00	SUBPROVIDER - IPF	180,285	0	180,285	3,682	48.96	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	334,067		334,067	9,444	35.37	44.00
200.00	Total (lines 30 through 199)	1,482,836		1,482,836	29,311		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	6,419	358,501	30.00
31.00	INTENSIVE CARE UNIT	869	83,354	31.00
40.00	SUBPROVIDER - IPF	2,529	123,820	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	5,874	207,763	44.00
200.00	Total (lines 30 through 199)	15,691	773,438	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,317,979	107,714,376	0.012236	8,150,491	99,729	50.00
51.00	05100	RECOVERY ROOM	33,723	24,240,639	0.001391	1,959,708	2,726	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	172,420	32,137,538	0.005365	2,142,990	11,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,986	22,625,790	0.025369	2,547,884	64,637	54.00
57.00	05700	CT SCAN	245,817	35,048,289	0.007014	4,265,048	29,915	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	784,262	18,896,333	0.041503	951,304	39,482	58.00
60.00	06000	LABORATORY	253,638	36,702,473	0.006911	6,340,112	43,817	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	13,977	1,988,811	0.007028	531,765	3,737	63.00
64.00	06400	INTRAVENOUS THERAPY	63,330	10,981,464	0.005767	1,232,769	7,109	64.00
65.00	06500	RESPIRATORY THERAPY	82,106	12,925,955	0.006352	4,505,917	28,622	65.00
66.00	06600	PHYSICAL THERAPY	94,955	8,228,031	0.011540	910,296	10,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,378	3,026,590	0.008385	303,472	2,545	67.00
68.00	06800	SPEECH PATHOLOGY	4,181	732,369	0.005709	160,444	916	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,411	405,444	0.210660	54,478	11,476	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,743	34,464,880	0.006666	5,412,904	36,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,373	31,069,255	0.006835	5,968,404	40,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,133	30,514,379	0.003544	5,463,804	19,364	73.00
74.00	07400	RENAL DIALYSIS	117,711	169,026	0.696408	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,329	1,108,240	0.002102	162,139	341	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	192,695	6,173,469	0.031213	825,195	25,757	76.02
76.03	03140	CARDIOLOGY	137,750	16,143,808	0.008533	3,376,243	28,809	76.03
76.97	07697	CARDIAC REHABILITATION	27,801	1,301,531	0.021360	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	276,224	18,004,855	0.015342	678,906	10,416	90.00
91.00	09100	EMERGENCY	240,145	24,646,014	0.009744	2,487,170	24,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	130,299	3,596,781	0.036227	399,880	14,486	92.00
200.00		Total (lines 50 through 199)	5,426,366	482,846,340		58,831,323	556,997	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	14,574	0.00	6,419	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,611	0.00	869	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,682	0.00	2,529	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	9,444	0.00	5,874	44.00
200.00		Total (lines 30 through 199)		0	29,311		15,691	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,714,376	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,240,639	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,137,538	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,625,790	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	35,048,289	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,896,333	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,702,473	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,988,811	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,981,464	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,925,955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,228,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,026,590	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	732,369	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	405,444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,464,880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,069,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,514,379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	169,026	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,108,240	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	6,173,469	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	16,143,808	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,301,531	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,004,855	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,646,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,596,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	482,846,340		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	8,150,491	0	25,440,681	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,959,708	0	4,305,014	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,142,990	0	7,121,205	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,547,884	0	4,910,363	0	54.00
57.00	05700	CT SCAN	0.000000	4,265,048	0	8,852,238	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	951,304	0	4,554,547	0	58.00
60.00	06000	LABORATORY	0.000000	6,340,112	0	3,460,743	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	531,765	0	443,183	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,232,769	0	2,261,162	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,505,917	0	869,369	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	910,296	0	92,296	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	303,472	0	12,878	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	160,444	0	5,415	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	54,478	0	53,333	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,412,904	0	5,309,893	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,968,404	0	4,916,859	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,463,804	0	4,968,139	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	162,139	0	316,468	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	825,195	0	1,385,665	0	76.02
76.03	03140	CARDIOLOGY	0.000000	3,376,243	0	2,543,282	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	585,932	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	678,906	0	3,594,271	0	90.00
91.00	09100	EMERGENCY	0.000000	2,487,170	0	4,579,118	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	399,880	0	782,380	0	92.00
200.00		Total (lines 50 through 199)		58,831,323	0	91,364,434	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 7:44 am

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	0.077823	25,440,681	0	0	1,979,870	50.00
51.00	05100	RECOVERY ROOM	0.118435	4,305,014	0	0	509,864	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	7,121,205	0	0	102,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	4,910,363	0	0	1,010,636	54.00
57.00	05700	CT SCAN	0.031009	8,852,238	0	0	274,499	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	4,554,547	0	0	479,229	58.00
60.00	06000	LABORATORY	0.118419	3,460,743	0	0	409,818	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	443,183	0	0	137,056	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	2,261,162	0	0	320,902	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	869,369	0	0	97,711	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	92,296	0	0	25,004	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	12,878	0	0	3,272	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	5,415	0	0	1,339	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	53,333	0	0	65,040	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	5,309,893	0	0	1,289,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	4,916,859	17,609	0	2,076,837	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	4,968,139	0	11,803	978,097	73.00
74.00	07400	RENAL DIALYSIS	2.101884	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	316,468	0	0	17,830	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	1,385,665	0	0	100,907	76.02
76.03	03140	CARDIOLOGY	0.085759	2,543,282	0	0	218,109	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	585,932	0	0	239,651	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.261744	3,594,271	0	0	940,779	90.00
91.00	09100	EMERGENCY	0.117090	4,579,118	0	0	536,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	782,380	0	0	394,733	92.00
200.00		Subtotal (see instructions)		91,364,434	17,609	11,803	12,209,291	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		91,364,434	17,609	11,803	12,209,291	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 7:44 am

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
51.00	05100	RECOVERY ROOM	0	0		51.00
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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,438	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,324		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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)	7,438	2,324		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,438	2,324		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,317,979	107,714,376	0.012236	0	0	50.00
51.00	05100	RECOVERY ROOM	33,723	24,240,639	0.001391	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	172,420	32,137,538	0.005365	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,986	22,625,790	0.025369	68,380	1,735	54.00
57.00	05700	CT SCAN	245,817	35,048,289	0.007014	222,286	1,559	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	784,262	18,896,333	0.041503	0	0	58.00
60.00	06000	LABORATORY	253,638	36,702,473	0.006911	337,852	2,335	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	13,977	1,988,811	0.007028	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	63,330	10,981,464	0.005767	15,559	90	64.00
65.00	06500	RESPIRATORY THERAPY	82,106	12,925,955	0.006352	238,374	1,514	65.00
66.00	06600	PHYSICAL THERAPY	94,955	8,228,031	0.011540	77,337	892	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,378	3,026,590	0.008385	6,769	57	67.00
68.00	06800	SPEECH PATHOLOGY	4,181	732,369	0.005709	24,406	139	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,411	405,444	0.210660	4,521	952	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,743	34,464,880	0.006666	72,390	483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,373	31,069,255	0.006835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,133	30,514,379	0.003544	126,030	447	73.00
74.00	07400	RENAL DIALYSIS	117,711	169,026	0.696408	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,329	1,108,240	0.002102	1,684	4	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	192,695	6,173,469	0.031213	0	0	76.02
76.03	03140	CARDIOLOGY	137,750	16,143,808	0.008533	52,700	450	76.03
76.97	07697	CARDIAC REHABILITATION	27,801	1,301,531	0.021360	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	276,224	18,004,855	0.015342	22,353	343	90.00
91.00	09100	EMERGENCY	240,145	24,646,014	0.009744	152,359	1,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,596,781	0.000000	5,005	0	92.00
200.00		Total (lines 50 through 199)	5,296,067	482,846,340		1,428,005	12,485	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,714,376	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,240,639	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,137,538	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,625,790	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	35,048,289	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,896,333	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,702,473	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,988,811	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,981,464	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,925,955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,228,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,026,590	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	732,369	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	405,444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,464,880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,069,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,514,379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	169,026	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,108,240	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	6,173,469	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	16,143,808	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,301,531	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,004,855	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,646,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,596,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	482,846,340		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	68,380	0	953	0	54.00
57.00	05700	CT SCAN	0.000000	222,286	0	3,337	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	337,852	0	37	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	15,559	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	238,374	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	77,337	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	6,769	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	24,406	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,521	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	72,390	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	126,030	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	1,684	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	52,700	0	796	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	22,353	0	780	0	90.00
91.00	09100	EMERGENCY	0.000000	152,359	0	1,630	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,005	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,428,005	0	7,533	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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	0.077823	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.118435	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	953	0	0	196	54.00
57.00	05700	CT SCAN	0.031009	3,337	0	0	103	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	0	0	0	0	58.00
60.00	06000	LABORATORY	0.118419	37	0	0	4	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	0	0	1,941	0	73.00
74.00	07400	RENAL DIALYSIS	2.101884	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.085759	796	0	0	68	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.261744	780	0	0	204	90.00
91.00	09100	EMERGENCY	0.117090	1,630	0	0	191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	0	0	0	0	92.00
200.00		Subtotal (see instructions)		7,533	0	1,941	766	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		7,533	0	1,941	766	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0		51.00
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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	382		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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)	0	382		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	382		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Skilled Nursing Facility | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,714,376	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,240,639	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,137,538	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,625,790	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	35,048,289	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,896,333	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,702,473	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,988,811	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,981,464	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,925,955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,228,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,026,590	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	732,369	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	405,444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,464,880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,069,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,514,379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	169,026	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,108,240	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	6,173,469	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	16,143,808	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,301,531	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,004,855	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,646,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,596,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	482,846,340		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Skilled Nursing Facility | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	116,068	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	8,374	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	799,258	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	25,910	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,484	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,034,524	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,314,326	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,947,050	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	200,627	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,964	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	517,789	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	14,142	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	19,829	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	152,351	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		9,158,696	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	813,960	0	813,960	14,574	55.85	30.00
31.00	INTENSIVE CARE UNIT	154,524		154,524	1,611	95.92	31.00
40.00	SUBPROVIDER - IPF	180,285	0	180,285	3,682	48.96	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	334,067		334,067	9,444	35.37	44.00
200.00	Total (lines 30 through 199)	1,482,836		1,482,836	29,311		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	707	39,486				30.00
31.00	INTENSIVE CARE UNIT	66	6,331				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	773	45,817				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,317,979	107,714,376	0.012236	0	0	50.00
51.00	05100	RECOVERY ROOM	33,723	24,240,639	0.001391	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	172,420	32,137,538	0.005365	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,986	22,625,790	0.025369	0	0	54.00
57.00	05700	CT SCAN	245,817	35,048,289	0.007014	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	784,262	18,896,333	0.041503	0	0	58.00
60.00	06000	LABORATORY	253,638	36,702,473	0.006911	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	13,977	1,988,811	0.007028	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	63,330	10,981,464	0.005767	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	82,106	12,925,955	0.006352	0	0	65.00
66.00	06600	PHYSICAL THERAPY	94,955	8,228,031	0.011540	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,378	3,026,590	0.008385	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,181	732,369	0.005709	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,411	405,444	0.210660	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,743	34,464,880	0.006666	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,373	31,069,255	0.006835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,133	30,514,379	0.003544	0	0	73.00
74.00	07400	RENAL DIALYSIS	117,711	169,026	0.696408	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,329	1,108,240	0.002102	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	192,695	6,173,469	0.031213	0	0	76.02
76.03	03140	CARDIOLOGY	137,750	16,143,808	0.008533	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	27,801	1,301,531	0.021360	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	276,224	18,004,855	0.015342	0	0	90.00
91.00	09100	EMERGENCY	240,145	24,646,014	0.009744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	130,299	3,596,781	0.036227	0	0	92.00
200.00		Total (lines 50 through 199)	5,426,366	482,846,340		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	14,574	0.00	707	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,611	0.00	66	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,682	0.00	0	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	9,444	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	29,311		773	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,714,376	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,240,639	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,137,538	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,625,790	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	35,048,289	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,896,333	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,702,473	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,988,811	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,981,464	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,925,955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,228,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,026,590	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	732,369	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	405,444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,464,880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,069,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,514,379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	169,026	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,108,240	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	6,173,469	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	16,143,808	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,301,531	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,004,855	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,646,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,596,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	482,846,340		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,317,979	107,714,376	0.012236	0	0	50.00
51.00	05100	RECOVERY ROOM	33,723	24,240,639	0.001391	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	172,420	32,137,538	0.005365	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,986	22,625,790	0.025369	0	0	54.00
57.00	05700	CT SCAN	245,817	35,048,289	0.007014	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	784,262	18,896,333	0.041503	0	0	58.00
60.00	06000	LABORATORY	253,638	36,702,473	0.006911	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	13,977	1,988,811	0.007028	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	63,330	10,981,464	0.005767	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	82,106	12,925,955	0.006352	0	0	65.00
66.00	06600	PHYSICAL THERAPY	94,955	8,228,031	0.011540	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,378	3,026,590	0.008385	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,181	732,369	0.005709	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,411	405,444	0.210660	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,743	34,464,880	0.006666	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,373	31,069,255	0.006835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,133	30,514,379	0.003544	0	0	73.00
74.00	07400	RENAL DIALYSIS	117,711	169,026	0.696408	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,329	1,108,240	0.002102	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	192,695	6,173,469	0.031213	0	0	76.02
76.03	03140	CARDIOLOGY	137,750	16,143,808	0.008533	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	27,801	1,301,531	0.021360	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	276,224	18,004,855	0.015342	0	0	90.00
91.00	09100	EMERGENCY	240,145	24,646,014	0.009744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,596,781	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,296,067	482,846,340		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,714,376	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,240,639	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,137,538	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,625,790	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	35,048,289	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,896,333	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,702,473	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,988,811	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,981,464	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,925,955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,228,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,026,590	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	732,369	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	405,444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,464,880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,069,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,514,379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	169,026	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,108,240	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	6,173,469	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	16,143,808	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,301,531	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,004,855	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,646,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,596,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	482,846,340		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Subprovider - IPF | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Skilled Nursing Facility | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,714,376	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,240,639	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,137,538	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,625,790	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	35,048,289	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,896,333	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,702,473	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,988,811	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,981,464	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,925,955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,228,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,026,590	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	732,369	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	405,444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34,464,880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,069,255	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,514,379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	169,026	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,108,240	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	6,173,469	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	16,143,808	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,301,531	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	18,004,855	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,646,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,596,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	482,846,340		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Skilled Nursing Facility | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,574	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,574	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)	12,241	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)	6,419	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)	11,336,023	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)	11,336,023	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)	11,336,023	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)	777.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,992,891	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)	4,992,891	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,394,101	1,611	1,486.10	869	1,291,421	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)	9,621,086	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,905,398	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)	441,855	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	556,997	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	998,852	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,906,546	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,333	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	777.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,814,677	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	813,960	11,336,023	0.071803	1,814,677	130,299	90.00
91.00	Nursing School cost	0	11,336,023	0.000000	1,814,677	0	91.00
92.00	Allied health cost	0	11,336,023	0.000000	1,814,677	0	92.00
93.00	All other Medical Education	0	11,336,023	0.000000	1,814,677	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Subprovider - IPF	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)	3,682	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,682	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,682	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)	2,529	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)	3,118,306	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)	3,118,306	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,118,306	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)	846.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,141,835	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,141,835	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	197,415	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,339,250	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)	123,820	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,485	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	136,305	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,202,945	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 14-S013 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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	180,285	3,118,306	0.057815	0	0	90.00
91.00	Nursing School cost	0	3,118,306	0.000000	0	0	91.00
92.00	Allied health cost	0	3,118,306	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,118,306	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Skilled Nursing Facility	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)	9,444	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,444	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)	9,444	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)	5,874	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)	3,591,640	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)	3,591,640	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,591,640	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,591,640	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	380.31	71.00
72.00	Program routine service cost (line 9 x line 71)	2,233,941	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,233,941	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,233,941	83.00
84.00	Program inpatient ancillary services (see instructions)	1,943,896	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,177,837	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | 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)	14,574	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,574	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)	12,241	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)	707	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)	11,336,023	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)	11,336,023	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)	11,336,023	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)	777.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	549,926	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)	549,926	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,394,101	1,611	1,486.10	66	98,083	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	648,009	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)	45,817	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	45,817	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	602,192	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,333	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	777.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,814,677	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | 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	813,960	11,336,023	0.071803	1,814,677	130,299	90.00
91.00	Nursing School cost	0	11,336,023	0.000000	1,814,677	0	91.00
92.00	Allied health cost	0	11,336,023	0.000000	1,814,677	0	92.00
93.00	All other Medical Education	0	11,336,023	0.000000	1,814,677	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 7:44 am
	Title XIX	Subprovider - IPF	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)	3,682	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,682	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,682	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)	0	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)	3,118,306	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)	3,118,306	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,118,306	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)	846.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Subprovider - IPF | PPS

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

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Subprovider - IPF | 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	180,285	3,118,306	0.057815	0	0	90.00
91.00	Nursing School cost	0	3,118,306	0.000000	0	0	91.00
92.00	Allied health cost	0	3,118,306	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,118,306	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 7:44 am
	Title XIX	Skilled Nursing Facility	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)	9,444	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,444	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)	9,444	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)	0	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)	3,591,640	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)	3,591,640	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,591,640	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 7:44 am

Title XIX | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,591,640	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	380.31	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	334,067	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	35.37	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 7:44 am
	Title XIX	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		16,988,075		30.00
31.00	03100	INTENSIVE CARE UNIT		4,241,461		31.00
40.00	04000	SUBPROVIDER - IPF		2,287		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077823	8,150,491	634,296	50.00
51.00	05100	RECOVERY ROOM	0.118435	1,959,708	232,098	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	2,142,990	30,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	2,547,884	524,398	54.00
57.00	05700	CT SCAN	0.031009	4,265,048	132,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	951,304	100,096	58.00
60.00	06000	LABORATORY	0.118419	6,340,112	750,790	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	531,765	164,450	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	1,232,769	174,953	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	4,505,917	506,434	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	910,296	246,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	303,472	77,109	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	160,444	39,670	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	54,478	66,436	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	5,412,904	1,314,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	5,968,404	2,521,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	5,463,804	1,075,681	73.00
74.00	07400	RENAL DIALYSIS	2.101884	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	162,139	9,135	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	825,195	60,092	76.02
76.03	03140	CARDIOLOGY	0.085759	3,376,243	289,543	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.261744	678,906	177,700	90.00
91.00	09100	EMERGENCY	0.117093	2,487,170	291,230	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	399,880	201,751	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,831,323	9,621,086	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)		58,831,323		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		5,783,823		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077823	0	0	50.00
51.00	05100	RECOVERY ROOM	0.118435	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	68,380	14,074	54.00
57.00	05700	CT SCAN	0.031009	222,286	6,893	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	0	0	58.00
60.00	06000	LABORATORY	0.118419	337,852	40,008	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	15,559	2,208	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	238,374	26,792	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	77,337	20,951	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	6,769	1,720	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	24,406	6,034	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	4,521	5,513	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	72,390	17,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	126,030	24,812	73.00
74.00	07400	RENAL DIALYSIS	2.101884	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	1,684	95	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	0	0	76.02
76.03	03140	CARDIOLOGY	0.085759	52,700	4,519	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.261744	22,353	5,851	90.00
91.00	09100	EMERGENCY	0.117093	152,359	17,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	5,005	2,525	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,428,005	197,415	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,428,005		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Skilled Nursing Facility | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077823	0	0	50.00
51.00	05100	RECOVERY ROOM	0.118435	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014381	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205817	116,068	23,889	54.00
57.00	05700	CT SCAN	0.031009	8,374	260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105220	0	0	58.00
60.00	06000	LABORATORY	0.118419	799,258	94,647	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.309254	25,910	8,013	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141919	1,484	211	64.00
65.00	06500	RESPIRATORY THERAPY	0.112393	2,034,524	228,666	65.00
66.00	06600	PHYSICAL THERAPY	0.270907	3,314,326	897,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254090	1,947,050	494,726	67.00
68.00	06800	SPEECH PATHOLOGY	0.247252	200,627	49,605	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.219500	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242854	6,964	1,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.422391	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196874	517,789	101,939	73.00
74.00	07400	RENAL DIALYSIS	2.101884	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056341	14,142	797	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.072822	0	0	76.02
76.03	03140	CARDIOLOGY	0.085759	19,829	1,701	76.03
76.97	07697	CARDIAC REHABILITATION	0.409008	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.261744	152,351	39,877	90.00
91.00	09100	EMERGENCY	0.117093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.504528	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,158,696	1,943,896	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)		9,158,696		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	10,157,605	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,712,661	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)	93,908	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)	103.61	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.36	30.00
31.00	Percentage of Medicaid patient days (see instructions)	5.57	31.00
32.00	Sum of lines 30 and 31	7.93	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	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)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		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)	13,964,174		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)	13,964,174	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,143,208	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)	15,107,382	59.00
60.00	Primary payer payments	2,079	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	15,105,303	61.00
62.00	Deductibles billed to program beneficiaries	1,780,500	62.00
63.00	Coinsurance billed to program beneficiaries	23,115	63.00
64.00	Allowable bad debts (see instructions)	211,345	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	137,374	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	176,774	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	13,439,062	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)	-28,299	70.93
70.94	HRR adjustment amount (see instructions)	-339,730	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	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)		13,071,033	71.00
71.01	Sequestration adjustment (see instructions)		261,421	71.01
71.02	Demonstration payment adjustment amount after sequestration		123,865	71.02
72.00	Interim payments		12,651,490	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)		34,257	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,157,605	0	10,157,605		10,157,605	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,712,661	0		3,712,661	3,712,661	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	93,908	0	76,782	17,126	93,908	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,964,174	0	10,234,387	3,729,787	13,964,174	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,964,174	0	10,234,387	3,729,787	13,964,174	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,143,208	0	837,869	305,339	1,143,208	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2019 7:44 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	11,072,256	4,035,126	15,107,382	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,120,653	0	820,904	299,749	1,120,653	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,400	0	3,666	734	4,400	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0162	0.0162	0.0162	0.0162		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	18,155	0	13,299	4,856	18,155	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,143,208	0	837,869	305,339	1,143,208	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,157,605	10,157,605		10,157,605	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,712,661		3,712,661	3,712,661	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	93,908	76,782	17,126	93,908	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,964,174	10,234,387	3,729,787	13,964,174	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,964,174	10,234,387	3,729,787	13,964,174	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,143,208	837,869	305,339	1,143,208	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			11,072,256	4,035,126	15,107,382	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 7:44 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,120,653	820,904	299,749	1,120,653	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,400	3,666	734	4,400	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0162	0.0162	0.0162		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	18,155	13,299	4,856	18,155	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,143,208	837,869	305,339	1,143,208	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-28,299	-37,732	9,433	-28,299	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-339,730	-230,577	-109,153	-339,730	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,762	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,209,291	2.00
3.00	OPPS payments	10,890,213	3.00
4.00	Outlier payment (see instructions)	15,091	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,762	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	29,412	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)	29,412	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)	29,412	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19,650	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,762	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)	10,905,304	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	3,522	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,173,472	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)	8,738,072	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)	8,738,072	30.00
31.00	Primary payer payments	2,119	31.00
32.00	Subtotal (line 30 minus line 31)	8,735,953	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)	241,983	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	157,289	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	185,995	36.00
37.00	Subtotal (see instructions)	8,893,242	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-17	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)	8,893,259	40.00
40.01	Sequestration adjustment (see instructions)	177,865	40.01
40.02	Demonstration payment adjustment amount after sequestration	84,348	40.02
41.00	Interim payments	8,599,259	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	31,787	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	382	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	766	2.00
3.00	OPPS payments	1,075	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	382	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,941	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)	1,941	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)	1,941	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,559	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)	382	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)	1,075	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	131	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)	1,326	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)	1,326	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,326	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,326	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)	1,326	40.00
40.01	Sequestration adjustment (see instructions)	27	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,477	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-178	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: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 7:44 am

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		12,651,490		8,599,259	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)		12,651,490		8,599,259	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		34,257		31,787	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		12,685,747		8,631,046	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Subprovider - IPF | 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		2,015,460		1,477	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)		2,015,460		1,477	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		7		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		178	6.02
7.00	Total Medicare program liability (see instructions)		2,015,467		1,299	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 7:44 am

Title XVIII | Skilled Nursing Facility | 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		2,721,634		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		2,721,634		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,721,634		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,226,533	1.00
2.00	Net IPF PPS Outlier Payments	4,840	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.087671	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,231,373	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,231,373	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,231,373	18.00
19.00	Deductibles	154,004	19.00
20.00	Subtotal (line 18 minus line 19)	2,077,369	20.00
21.00	Coinsurance	20,770	21.00
22.00	Subtotal (line 20 minus line 21)	2,056,599	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,056,599	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,056,599	31.00
31.01	Sequestration adjustment (see instructions)	41,132	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,015,460	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	7	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	4,840	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	2,961,037	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,961,037	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	139,695	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	2,821,342	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	2,821,342	15.00
15.01	Sequestration adjustment (see instructions)	56,427	15.01
15.02	Demonstration payment adjustment amount after sequestration	43,281	15.02
16.00	Interim payments	2,721,634	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/28/2019 7:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,249,697	0	0	0	1.00
2.00	Temporary investments	190,130	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,442,849	0	0	0	4.00
5.00	Other receivable	2,948,431	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,280,808	0	0	0	7.00
8.00	Prepaid expenses	342,981	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	31,864,156	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	60,319,052	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,081,907	0	0	0	12.00
13.00	Land improvements	882,034	0	0	0	13.00
14.00	Accumulated depreciation	-6,288,391	0	0	0	14.00
15.00	Buildings	30,467,572	0	0	0	15.00
16.00	Accumulated depreciation	-49,672,456	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	3,265,804	0	0	0	19.00
20.00	Accumulated depreciation	-18,744,877	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	122,814,076	0	0	0	23.00
24.00	Accumulated depreciation	-51,620,369	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	37,185,300	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,186,995	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	6,180,539	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,367,534	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	109,871,886	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,365,398	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,224,901	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	13,061,270	0	0	0	43.00
44.00	Other current liabilities	3,100,666	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,752,235	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	31,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	33,015,249	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,046,249	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,798,484	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	54,073,402				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)	54,073,402	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	109,871,886	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 7:44 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		32,424,034		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		23,675,405				2.00
3.00	Total (sum of line 1 and line 2)		56,099,439		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN TEMP OR PERM RESTRICTIONS	1,006,724		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)		1,006,724		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,106,163		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN UNRESTRICTED FUND BALANCE	3,032,761		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,032,761		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		54,073,402		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2019 7:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	32,858,769		32,858,769	1.00
2.00	SUBPROVIDER - IPF	8,419,958		8,419,958	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	17,201,065		17,201,065	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)	58,479,792		58,479,792	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,819,133		7,819,133	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)	7,819,133		7,819,133	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	66,298,925		66,298,925	17.00
18.00	Ancillary services	125,385,969	0	125,385,969	18.00
19.00	Outpatient services	0	356,911,574	356,911,574	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		0	0	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	191,684,894	356,911,574	548,596,468	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,490,737		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)		82,490,737		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/28/2019 7:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	548,596,468	1.00
2.00	Less contractual allowances and discounts on patients' accounts	426,981,799	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,614,669	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,490,737	4.00
5.00	Net income from service to patients (line 3 minus line 4)	39,123,932	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	132,101	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	505,862	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER PROCTOR & HOME OFFICE REVENUE	3,340,671	24.00
25.00	Total other income (sum of lines 6-24)	3,978,634	25.00
26.00	Total (line 5 plus line 25)	43,102,566	26.00
27.00	PEORIA HOME OFFICE EXPENSES	19,427,161	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	19,427,161	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,675,405	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0013	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 7:44 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,120,653	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,400	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)		38.05	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)		2.36	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		5.57	8.00
9.00	Sum of lines 7 and 8		7.93	9.00
10.00	Allowable disproportionate share percentage (see instructions)		1.62	10.00
11.00	Disproportionate share adjustment (see instructions)		18,155	11.00
12.00	Total prospective capital payments (see instructions)		1,143,208	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