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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/31/2019 7:46 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2019 Time: 7:46 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 PEKIN MEMORIAL HOSPITAL (14-0120) 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)

_____
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	134,723	57,389	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	134,723	57,388	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 7:46 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 SOUTH 13TH STREET	PO Box:			1.00
2.00	City: PEKIN	State: IL	Zip Code: 61554	County: TAZEWELL	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PEKIN HOME HEALTH	147057	37900		01/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	549	0	0	1,167	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 7:46 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)	Y	Y	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2019 7:46 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 7:46 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 7:46 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 7:46 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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	195,639	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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 7:46 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: NATIONAL GOVERNMENT SERVICES, INC	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.			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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2019 7:46 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.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/08/2018	Y	05/08/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 7:46 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEITH		LYONS		41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITY POINT				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: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 7:46 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.	FINANCIAL 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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2019 7:46 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	99	36,135	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		99	36,135	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2019 7:46 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)	3,891	915	7,457			1.00
2.00	HMO and other (see instructions)	1,621	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	3,891	915	7,457			7.00
8.00	INTENSIVE CARE UNIT	389	77	858			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		360	566			13.00
14.00	Total (see instructions)	4,280	1,352	8,881	0.00	303.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	883	0	1,225	0.00	1.30	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	304.30	27.00
28.00	Observation Bed Days		335	1,902			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			51			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	363	691			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2019 7:46 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	1,044	272	2,825	1.00
2.00	HMO and other (see instructions)			394	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	1,044	272	2,825	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2019 7:46 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	16,342,306	0	16,342,306	449,880.00	36.33	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		86,999	153,323	240,322	12,019.00	20.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,546,252	0	1,546,252	46,892.00	32.97	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,842,499	0	3,842,499	108,942.00	35.27	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)		3,746,827	0	3,746,827			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		13,560	0	13,560			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	60,350	0	60,350	1,450.00	41.62	26.00
27.00	Administrative & General	5.00	505,529	0	505,529	14,482.00	34.91	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2019 7:46 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.)		131,223	0	131,223	517.00	253.82	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	468,710	0	468,710	14,608.00	32.09	30.00
31.00	Laundry & Linen Service	8.00	65,584	0	65,584	2,212.00	29.65	31.00
32.00	Housekeeping	9.00	585,840	0	585,840	33,587.00	17.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	690,800	-576,514	114,286	5,784.00	19.76	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	423,191	423,191	21,419.00	19.76	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	170,541	0	170,541	3,770.00	45.24	38.00
39.00	Central Services and Supply	14.00	349,138	0	349,138	13,253.00	26.34	39.00
40.00	Pharmacy	15.00	768,095	0	768,095	14,587.00	52.66	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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2019 7:46 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)		16,473,529	0	16,473,529	450,397.00	36.58	1.00
2.00	Excluded area salaries (see instructions)		86,999	153,323	240,322	12,019.00	20.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		16,386,530	-153,323	16,233,207	438,378.00	37.03	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,388,751	0	5,388,751	155,834.00	34.58	4.00
5.00	Subtotal wage-related costs (see inst.)		3,746,827	0	3,746,827	0.00	23.08	5.00
6.00	Total (sum of lines 3 thru 5)		25,522,108	-153,323	25,368,785	594,212.00	42.69	6.00
7.00	Total overhead cost (see instructions)		3,795,810	-153,323	3,642,487	125,669.00	28.98	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2019 7:46 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	173,452	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)	781,710	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)	2,477,934	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	115,380	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	6,484	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)	-27,792	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	303,369	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,191,131	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	61,155	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	35,091	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,117,914	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2019 7:46 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	1,546,252	5,117,914	1.00
2.00	Hospital	1,546,252	5,117,914	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	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

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-0120
Component CCN: 14-7057
Period: From 01/01/2018 To 12/31/2018
Worksheet S-4
Date/Time Prepared: 5/31/2019 7:46 am

Home Health Agency I | PPS

		1.00	
0.00	County	TAZEWELL	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	540	0	0	540	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	55.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.30	0.00	0.30	5.00
6.00	Direct Nursing Service		0.95	0.00	0.95	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.26	0.00	0.26	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		37900			20.00
20.01			99914			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	279	0	8	15	302	21.00
22.00	Skilled Nursing Visit Charges	48,546	0	1,392	2,610	52,548	22.00
23.00	Physical Therapy Visits	410	0	2	21	433	23.00
24.00	Physical Therapy Visit Charges	77,900	0	380	3,990	82,270	24.00
25.00	Occupational Therapy Visits	99	0	1	1	101	25.00
26.00	Occupational Therapy Visit Charges	19,008	0	192	192	19,392	26.00
27.00	Speech Pathology Visits	19	0	0	0	19	27.00
28.00	Speech Pathology Visit Charges	3,933	0	0	0	3,933	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	28	0	0	0	28	31.00
32.00	Home Health Aide Visit Charges	2,212	0	0	0	2,212	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	835	0	11	37	883	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	151,599	0	1,964	6,792	160,355	35.00
36.00	Total Number of Episodes (standard/non outlier)	49		4	3	56	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	128	0	0	0	128	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/31/2019 7:46 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)	0.178712	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,549,260	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	50,726,009	6.00
7.00	Medicaid cost (line 1 times line 6)	9,065,347	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)	4,516,087	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)	4,516,087	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)	6,666,891	267,061	6,933,952	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,191,453	267,061	1,458,514	21.00
22.00	Payments received from patients for amounts previously written off as charity care	40,522	532	41,054	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,150,931	266,529	1,417,460	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)	5,835,941	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	106,455	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	163,778	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,672,163	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,071,007	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,488,467	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,004,554	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/31/2019 7:46 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		706,034	706,034	348,782	1,054,816	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	80,051	80,051	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,350	657,228	717,578	0	717,578	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	505,529	2,405,857	2,911,386	-131,594	2,779,792	5.00
7.00	00700	OPERATION OF PLANT	468,710	2,444,163	2,912,873	-1,345	2,911,528	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,584	58,438	124,022	0	124,022	8.00
9.00	00900	HOUSEKEEPING	585,840	399,003	984,843	-334	984,509	9.00
10.00	01000	DIETARY	690,800	537,686	1,228,486	-1,025,978	202,508	10.00
11.00	01100	CAFETERIA	0	0	0	752,582	752,582	11.00
13.00	01300	NURSING ADMINISTRATION	170,541	143,424	313,965	-377	313,588	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	349,138	417,957	767,095	-64,861	702,234	14.00
15.00	01500	PHARMACY	768,095	1,963,284	2,731,379	-1,471,774	1,259,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,191,731	1,545,329	5,737,060	-2,467,278	3,269,782	30.00
31.00	03100	INTENSIVE CARE UNIT	629,231	186,706	815,937	-102,507	713,430	31.00
43.00	04300	NURSERY	0	0	0	158,116	158,116	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,196,952	4,922,383	7,119,335	-3,419,647	3,699,688	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	873,355	873,355	52.00
53.00	05300	ANESTHESIOLOGY	0	925,950	925,950	-162,689	763,261	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,095,910	598,698	1,694,608	313,445	2,008,053	54.00
56.00	05600	RADIOISOTOPE	143,335	202,543	345,878	-343,842	2,036	56.00
57.00	05700	CT SCAN	294,007	149,671	443,678	-60,665	383,013	57.00
58.00	05800	MRI	119,934	239,007	358,941	-7,770	351,171	58.00
59.00	05900	CARDIAC CATHETERIZATION	228,959	476,482	705,441	-491,799	213,642	59.00
60.00	06000	LABORATORY	843,745	1,440,133	2,283,878	-230,850	2,053,028	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	188,466	188,466	103,081	291,547	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,369,549	1,369,549	64.00
65.00	06500	RESPIRATORY THERAPY	374,949	140,051	515,000	38,933	553,933	65.00
66.00	06600	PHYSICAL THERAPY	0	745,300	745,300	-218,982	526,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	82,709	82,709	171,849	254,558	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,337	70,337	70,442	140,779	68.00
69.00	06900	ELECTROCARDIOLOGY	233,301	84,852	318,153	-10,447	307,706	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,058,723	3,058,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,451,894	2,451,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,557,150	1,557,150	73.00
74.00	07400	RENAL DIALYSIS	0	808	808	-808	0	74.00
76.00	03610	SLEEP LAB	20,460	556,301	576,761	-475,704	101,057	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	376,781	226,716	603,497	412,954	1,016,451	90.00
91.00	09100	EMERGENCY	1,841,425	2,129,082	3,970,507	-1,020,590	2,949,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	71,382	97,246	168,628	-1,501	167,127	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		477,883	477,883	-322,227	155,656	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,326,689	25,219,727	41,546,416	-272,663	41,273,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,617	7,195	22,812	272,663	295,475	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	16,342,306	25,226,922	41,569,228	0	41,569,228	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/31/2019 7:46 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	0	1,054,816		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	80,051		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-888,002	-170,424		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,177,607	8,957,399		5.00
7.00	00700	OPERATION OF PLANT	107,570	3,019,098		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,022		8.00
9.00	00900	HOUSEKEEPING	-26,643	957,866		9.00
10.00	01000	DIETARY	0	202,508		10.00
11.00	01100	CAFETERIA	-346,708	405,874		11.00
13.00	01300	NURSING ADMINISTRATION	793,596	1,107,184		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	702,234		14.00
15.00	01500	PHARMACY	0	1,259,605		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	471,475	471,475		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-80	3,269,702		30.00
31.00	03100	INTENSIVE CARE UNIT	0	713,430		31.00
43.00	04300	NURSERY	0	158,116		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-176,125	3,523,563		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	873,355		52.00
53.00	05300	ANESTHESIOLOGY	-763,261	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,617	2,005,436		54.00
56.00	05600	RADIOISOTOPE	0	2,036		56.00
57.00	05700	CT SCAN	0	383,013		57.00
58.00	05800	MRI	0	351,171		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	213,642		59.00
60.00	06000	LABORATORY	-67,500	1,985,528		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	291,547		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,369,549		64.00
65.00	06500	RESPIRATORY THERAPY	0	553,933		65.00
66.00	06600	PHYSICAL THERAPY	0	526,318		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	254,558		67.00
68.00	06800	SPEECH PATHOLOGY	0	140,779		68.00
69.00	06900	ELECTROCARDIOLOGY	0	307,706		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,058,723		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,451,894		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,557,150		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03610	SLEEP LAB	0	101,057		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-124,449	892,002		90.00
91.00	09100	EMERGENCY	-1,052,202	1,897,715		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	167,127		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-155,656	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,947,005	45,220,758		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	295,475		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	LEASED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	3,947,005	45,516,233		200.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/31/2019 7:46 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	423,191	329,391		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	153,323	119,340		2.00
	0		576,514	448,731		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,058,723		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
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	0		0	3,058,723		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,557,150		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
	0		0	1,557,150		
	G - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,451,894		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
	TOTALS		0	2,451,894		
	I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	322,227		1.00
	0		0	322,227		
	J - TO RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,555		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	80,051		2.00
	0		0	106,606		

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/31/2019 7:46 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - COST CENTER MAPPING				
1.00	ADULTS & PEDIATRICS	30.00	8,443	2,487	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	15	2.00
3.00	NURSERY	43.00	131,316	26,800	3.00
4.00	OPERATING ROOM	50.00	323,462	148,454	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	725,326	148,029	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	216,133	230,414	6.00
7.00	BLOOD STORING, PROCESSING & TRANS.	63.00	56,742	46,386	7.00
8.00	INTRAVENOUS THERAPY	64.00	860,623	508,926	8.00
9.00	RESPIRATORY THERAPY	65.00	64,474	39,834	9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	171,849	10.00
11.00	SPEECH PATHOLOGY	68.00	21,133	49,309	11.00
12.00	CLINIC	90.00	129,661	304,677	12.00
	TOTALS		2,537,313	1,677,180	
	N - TO RECLASS ANESTHESIOLOGY EXPENSE				
1.00	OPERATING ROOM	50.00	0	24,959	1.00
	0		0	24,959	
500.00	Grand Total: Increases		3,113,827	9,647,470	500.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/31/2019 7:46 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	576,514	448,731	0		1.00
2.00		0.00	0	0	0		2.00
	0		576,514	448,731			
	E - TO RECLASS SUPPLY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,988	0		1.00
2.00	OPERATION OF PLANT	7.00	0	1,345	0		2.00
3.00	HOUSEKEEPING	9.00	0	334	0		3.00
4.00	DIETARY	10.00	0	386	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	377	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	48,060	0		6.00
7.00	PHARMACY	15.00	0	20,573	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	300,692	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,388	0		9.00
10.00	OPERATING ROOM	50.00	0	1,683,452	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	118,828	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	76,003	0		12.00
13.00	RADIOISOTOPE	56.00	0	6,674	0		13.00
14.00	CT SCAN	57.00	0	47,492	0		14.00
15.00	MRI	58.00	0	4,496	0		15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	141,914	0		16.00
17.00	LABORATORY	60.00	0	164,788	0		17.00
18.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	47	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	64,097	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	2,137	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	10,447	0		21.00
22.00	RENAL DIALYSIS	74.00	0	774	0		22.00
23.00	SLEEP LAB	76.00	0	90,968	0		23.00
24.00	CLINIC	90.00	0	15,761	0		24.00
25.00	EMERGENCY	91.00	0	231,204	0		25.00
26.00	HOME HEALTH AGENCY	101.00	0	1,498	0		26.00
	0		0	3,058,723			
	F - TO RECLASS BILLABLE DRUGS						
1.00	DIETARY	10.00	0	347	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,852	0		2.00
3.00	PHARMACY	15.00	0	1,451,190	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,583	0		4.00
5.00	OPERATING ROOM	50.00	0	19,064	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	18,902	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,733	0		7.00
8.00	RADIOISOTOPE	56.00	0	64	0		8.00
9.00	CT SCAN	57.00	0	13,173	0		9.00
10.00	MRI	58.00	0	3,274	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	561	0		11.00
12.00	LABORATORY	60.00	0	4,610	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	1,278	0		13.00
14.00	RENAL DIALYSIS	74.00	0	19	0		14.00
15.00	SLEEP LAB	76.00	0	631	0		15.00
16.00	CLINIC	90.00	0	129	0		16.00
17.00	EMERGENCY	91.00	0	8,737	0		17.00
18.00	HOME HEALTH AGENCY	101.00	0	3	0		18.00
	0		0	1,557,150			
	G - IMPLANTIBLES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,949	0		1.00
2.00	PHARMACY	15.00	0	11	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,307	0		3.00
4.00	OPERATING ROOM	50.00	0	2,214,006	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	200	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	136,868	0		6.00
7.00	SLEEP LAB	76.00	0	96,553	0		7.00
	TOTALS		0	2,451,894			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	322,227	11		1.00
	0		0	322,227			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	106,606	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	106,606			
	K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	1,751,045	417,581	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	78,125	23,009	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	30,416	12,750	0		3.00
4.00	RADIOISOTOPE	56.00	142,475	194,629	0		4.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/31/2019 7:46 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00	CARDIAC CATHETERIZATION	59.00	114,161	98,295	0		5.00
6.00	LABORATORY	60.00	25,170	36,282	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	216,845	0		7.00
8.00	RENAL DIALYSIS	74.00	0	15	0		8.00
9.00	SLEEP LAB	76.00	7,533	280,019	0		9.00
10.00	CLINIC	90.00	3,157	2,337	0		10.00
11.00	EMERGENCY	91.00	385,231	395,418	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		2,537,313	1,677,180			
	N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	24,959	0		1.00
	0		0	24,959			
500.00	Grand Total: Decreases		3,113,827	9,647,470			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2019 7:46 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,250,000	0	0	0	0	1.00
2.00	Land Improvements	1,956,871	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	0	0	0	3.00
4.00	Building Improvements	23,852,165	0	0	0	2,555,598	4.00
5.00	Fixed Equipment	19,689,894	326,646	0	326,646	0	5.00
6.00	Movable Equipment	31,985,613	2,969,319	0	2,969,319	28,729	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	91,320,489	3,295,965	0	3,295,965	2,584,327	8.00
9.00	Reconciling Items	3,355,931	0	0	0	3,355,931	9.00
10.00	Total (line 8 minus line 9)	87,964,558	3,295,965	0	3,295,965	-771,604	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,250,000	0	1.00
2.00	Land Improvements	1,956,871	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	3.00
4.00	Building Improvements	21,296,567	0	4.00
5.00	Fixed Equipment	20,016,540	0	5.00
6.00	Movable Equipment	34,926,203	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	92,032,127	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	92,032,127	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2019 7:46 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	706,034	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)	706,034	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	706,034		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	706,034		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2019 7:46 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	57,105,924	0	57,105,924	0.620500	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,926,203	0	34,926,203	0.379500	0	2.00
3.00	Total (sum of lines 1-2)	92,032,127	0	92,032,127	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	706,034	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)	0	0	0	706,034	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	322,227	26,555	0	0	1,054,816	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	80,051	0	0	80,051	2.00
3.00	Total (sum of lines 1-2)	322,227	106,606	0	0	1,134,867	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/31/2019 7:46 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	-1,420,276			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	7,872,004			0	12.00
13.00	Laundry and linen service	B	0	HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B	-328,190	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MOW & CATERING	B	-18,518	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/31/2019 7:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANOUS REVENUE	B	-95	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISCELLANOUS REVENUE	B	-26,643	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANOUS REVENUE	B	-50,700	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISCELLANOUS REVENUE	B	-80	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	MISCELLANOUS REVENUE	B	-2,617	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.13
33.14	CRNA - PURCHASED SERVICES	A	-763,261	ANESTHESIOLOGY	53.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-1,150,724	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	REMOVE NON-ALLOWABLE INTEREST	A	-163,895	INTEREST EXPENSE	113.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,947,005				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/31/2019 7:46 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	PEORIA HOME OFFICE	262,817	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	PEORIA HOME OFFICE	471,475	0	2.00
3.00	13.00	NURSING ADMINISTRATION	PEORIA HOME OFFICE	844,296	0	3.00
4.00	7.00	OPERATION OF PLANT	PEORIA HOME OFFICE	107,570	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	PEORIA HOME OFFICE	6,177,607	0	4.01
4.02	113.00	INTEREST EXPENSE	PEORIA HOME OFFICE	299,376	291,137	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,163,141	291,137	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: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/31/2019 7:46 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	262,817	9		1.00
2.00	471,475	0		2.00
3.00	844,296	0		3.00
4.00	107,570	0		4.00
4.01	6,177,607	0		4.01
4.02	8,239	0		4.02
5.00	7,872,004			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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2019 7:46 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	50.00	OPERATING ROOM	176,125	176,125	0	0	0	1.00
2.00	60.00	LABORATORY	67,500	67,500	0	0	0	2.00
3.00	90.00	CLINIC	130,550	119,930	10,620	211,500	60	3.00
4.00	91.00	EMERGENCY	1,052,202	1,052,202	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,426,377	1,415,757	10,620		60	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	6,101	305	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,101	305	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	50.00	OPERATING ROOM	0	0	0	176,125		1.00
2.00	60.00	LABORATORY	0	0	0	67,500		2.00
3.00	90.00	CLINIC	0	6,101	4,519	124,449		3.00
4.00	91.00	EMERGENCY	0	0	0	1,052,202		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	6,101	4,519	1,420,276		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,054,816	1,054,816				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	80,051		80,051			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-170,424	4,270	0	-166,154		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,957,399	350,380	556	0	9,308,335	5.00
7.00	00700	OPERATION OF PLANT	3,019,098	144,520	0	0	3,163,618	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	124,022	10,824	29,939	0	164,785	8.00
9.00	00900	HOUSEKEEPING	957,866	860	524	0	959,250	9.00
10.00	01000	DIETARY	202,508	20,607	146	0	223,261	10.00
11.00	01100	CAFETERIA	405,874	5,764	0	0	411,638	11.00
13.00	01300	NURSING ADMINISTRATION	1,107,184	27,829	0	0	1,135,013	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	702,234	15,002	1	0	717,237	14.00
15.00	01500	PHARMACY	1,259,605	4,962	980	0	1,265,547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	471,475	12,400	1,962	0	485,837	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,269,702	119,473	1,724	0	3,390,899	30.00
31.00	03100	INTENSIVE CARE UNIT	713,430	11,500	1,777	0	726,707	31.00
43.00	04300	NURSERY	158,116	2,989	88	0	161,193	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,523,563	60,100	12,565	0	3,596,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	873,355	9,694	486	0	883,535	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,005,436	45,156	8,216	0	2,058,808	54.00
56.00	05600	RADIOISOTOPE	2,036	2,524	1	0	4,561	56.00
57.00	05700	CT SCAN	383,013	2,221	1,203	0	386,437	57.00
58.00	05800	MRI	351,171	5,862	7,983	0	365,016	58.00
59.00	05900	CARDIAC CATHETERIZATION	213,642	2,207	2,496	0	218,345	59.00
60.00	06000	LABORATORY	1,985,528	17,365	1,445	0	2,004,338	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	291,547	0	64	0	291,611	63.00
64.00	06400	INTRAVENOUS THERAPY	1,369,549	0	1,150	0	1,370,699	64.00
65.00	06500	RESPIRATORY THERAPY	553,933	4,402	627	0	558,962	65.00
66.00	06600	PHYSICAL THERAPY	526,318	11,396	65	0	537,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	254,558	1,385	21	0	255,964	67.00
68.00	06800	SPEECH PATHOLOGY	140,779	5,331	20	0	146,130	68.00
69.00	06900	ELECTROCARDIOLOGY	307,706	15,365	1,162	0	324,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,058,723	0	0	0	3,058,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,451,894	0	0	0	2,451,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,557,150	0	0	0	1,557,150	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	101,057	2,135	417	0	103,609	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	892,002	5,831	1,367	0	899,200	90.00
91.00	09100	EMERGENCY	1,897,715	42,447	3,027	0	1,943,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	167,127	6,840	39	0	174,006	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,220,758	971,641	80,051	0	45,303,737	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	295,475	11,505	0	0	306,980	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	52,758	0	0	52,758	192.00
194.00	07950	VACANT SPACE	0	2,845	0	0	2,845	194.00
194.01	07951	LEASED SPACE	0	14,636	0	0	14,636	194.01
194.02	07952	FOUNDATION	0	1,431	0	0	1,431	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	-166,154	-166,154	201.00
202.00		TOTAL (sum lines 118 through 201)	45,516,233	1,054,816	80,051	-166,154	45,516,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,308,335					5.00
7.00	00700	OPERATION OF PLANT	809,589	3,973,207				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,169	77,402	284,356			8.00
9.00	00900	HOUSEKEEPING	245,478	6,148	0	1,210,876		9.00
10.00	01000	DIETARY	57,134	147,356	0	45,873	473,624	10.00
11.00	01100	CAFETERIA	105,341	41,218	0	12,831	0	11.00
13.00	01300	NURSING ADMINISTRATION	290,457	198,991	0	61,947	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	183,545	107,273	3,233	33,395	0	14.00
15.00	01500	PHARMACY	323,861	35,483	1,666	11,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,329	88,665	0	27,602	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	867,751	854,304	96,530	265,953	428,757	30.00
31.00	03100	INTENSIVE CARE UNIT	185,969	82,229	6,336	25,598	44,867	31.00
43.00	04300	NURSERY	41,250	21,372	0	6,653	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	920,292	429,752	70,855	133,785	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	226,102	69,315	0	21,578	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,861	322,892	0	100,518	0	54.00
56.00	05600	RADIOISOTOPE	1,167	18,051	42,092	5,619	0	56.00
57.00	05700	CT SCAN	98,892	15,885	0	4,945	0	57.00
58.00	05800	MRI	93,410	41,919	0	13,050	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	55,876	15,782	4,368	4,913	0	59.00
60.00	06000	LABORATORY	512,922	124,169	0	38,654	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	74,625	0	146	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	350,770	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	143,042	31,481	0	9,800	0	65.00
66.00	06600	PHYSICAL THERAPY	137,621	81,486	0	25,367	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,503	9,902	5,328	3,083	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,396	38,123	0	11,868	0	68.00
69.00	06900	ELECTROCARDIOLOGY	82,973	109,872	0	34,204	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	782,746	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	627,454	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	398,484	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	26,514	15,266	0	4,752	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	230,111	41,692	0	12,979	0	90.00
91.00	09100	EMERGENCY	497,274	303,521	53,802	94,488	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	44,529	48,912	0	15,227	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,211,437	3,378,461	284,356	1,025,728	473,624	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,558	82,270	0	25,611	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,501	377,250	0	117,441	0	192.00
194.00	07950	VACANT SPACE	728	20,341	0	6,332	0	194.00
194.01	07951	LEASED SPACE	3,745	104,653	0	32,579	0	194.01
194.02	07952	FOUNDATION	366	10,232	0	3,185	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,308,335	3,973,207	284,356	1,210,876	473,624	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	571,028					11.00
13.00	01300	NURSING ADMINISTRATION	5,648	1,692,056				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,157	0	1,063,840			14.00
15.00	01500	PHARMACY	22,034	0	0	1,659,637		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	726,433	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,156	1,420,748	0	0	431,693	30.00
31.00	03100	INTENSIVE CARE UNIT	21,712	163,471	0	0	20,980	31.00
43.00	04300	NURSERY	4,016	107,837	0	0	31,607	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,782	0	0	0	155,259	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,228	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,484	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	21	0	29,124	0	0	56.00
57.00	05700	CT SCAN	10,072	0	1,095	0	0	57.00
58.00	05800	MRI	4,338	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,672	0	0	0	0	59.00
60.00	06000	LABORATORY	33,760	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,212	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	31,248	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,601	0	0	0	59,388	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	644	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,075	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	573,722	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	459,899	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,659,637	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	430	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,408	0	0	0	0	90.00
91.00	09100	EMERGENCY	49,910	0	0	0	27,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,685	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	558,293	1,692,056	1,063,840	1,659,637	726,433	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,735	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	571,028	1,692,056	1,063,840	1,659,637	726,433	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	7,848,791	0	7,848,791		30.00
31.00	03100	INTENSIVE CARE UNIT	1,277,869	0	1,277,869		31.00
43.00	04300	NURSERY	373,928	0	373,928		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,394,953	0	5,394,953		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,222,758	0	1,222,758		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,056,563	0	3,056,563		54.00
56.00	05600	RADIOISOTOPE	100,635	0	100,635		56.00
57.00	05700	CT SCAN	517,326	0	517,326		57.00
58.00	05800	MRI	517,733	0	517,733		58.00
59.00	05900	CARDIAC CATHETERIZATION	302,956	0	302,956		59.00
60.00	06000	LABORATORY	2,713,843	0	2,713,843		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	368,594	0	368,594		63.00
64.00	06400	INTRAVENOUS THERAPY	1,752,717	0	1,752,717		64.00
65.00	06500	RESPIRATORY THERAPY	819,274	0	819,274		65.00
66.00	06600	PHYSICAL THERAPY	782,253	0	782,253		66.00
67.00	06700	OCCUPATIONAL THERAPY	339,780	0	339,780		67.00
68.00	06800	SPEECH PATHOLOGY	234,161	0	234,161		68.00
69.00	06900	ELECTROCARDIOLOGY	559,357	0	559,357		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,415,191	0	4,415,191		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,539,247	0	3,539,247		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,615,271	0	3,615,271		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03610	SLEEP LAB	150,571	0	150,571		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,255,390	0	1,255,390		90.00
91.00	09100	EMERGENCY	2,969,690	0	2,969,690		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	285,359	0	285,359		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,414,210	0	44,414,210		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	506,154	0	506,154		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	560,950	0	560,950		192.00
194.00	07950	VACANT SPACE	30,246	0	30,246		194.00
194.01	07951	LEASED SPACE	155,613	0	155,613		194.01
194.02	07952	FOUNDATION	15,214	0	15,214		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	-166,154	0	-166,154		201.00
202.00		TOTAL (sum lines 118 through 201)	45,516,233	0	45,516,233		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,270	0	4,270	4,270	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,521	350,380	556	365,457	0	5.00
7.00	00700	OPERATION OF PLANT	0	144,520	0	144,520	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	780,583	10,824	29,939	821,346	0	8.00
9.00	00900	HOUSEKEEPING	12,935	860	524	14,319	0	9.00
10.00	01000	DIETARY	3,809	20,607	146	24,562	0	10.00
11.00	01100	CAFETERIA	0	5,764	0	5,764	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,829	0	27,829	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45	15,002	1	15,048	0	14.00
15.00	01500	PHARMACY	83,026	4,962	980	88,968	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	247,100	12,400	1,962	261,462	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,196	119,473	1,724	173,393	0	30.00
31.00	03100	INTENSIVE CARE UNIT	48,691	11,500	1,777	61,968	0	31.00
43.00	04300	NURSERY	0	2,989	88	3,077	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,413	0	0	2,413	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	303,830	60,100	12,565	376,495	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,694	486	10,180	0	52.00
53.00	05300	ANESTHESIOLOGY	13,328	0	0	13,328	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,460	45,156	8,216	72,832	0	54.00
56.00	05600	RADIOISOTOPE	202,990	2,524	1	205,515	0	56.00
57.00	05700	CT SCAN	23	2,221	1,203	3,447	0	57.00
58.00	05800	MRI	31,279	5,862	7,983	45,124	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	208,058	2,207	2,496	212,761	0	59.00
60.00	06000	LABORATORY	77,437	17,365	1,445	96,247	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	39,628	0	64	39,692	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,658	0	1,150	3,808	0	64.00
65.00	06500	RESPIRATORY THERAPY	32,616	4,402	627	37,645	0	65.00
66.00	06600	PHYSICAL THERAPY	16,443	11,396	65	27,904	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,693	1,385	21	3,099	0	67.00
68.00	06800	SPEECH PATHOLOGY	553	5,331	20	5,904	0	68.00
69.00	06900	ELECTROCARDIOLOGY	533	15,365	1,162	17,060	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,335	0	0	30,335	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	03610	SLEEP LAB	10,866	2,135	417	13,418	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,029	5,831	1,367	42,227	0	90.00
91.00	09100	EMERGENCY	79,912	42,447	3,027	125,386	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	18,433	6,840	39	25,312	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,370,423	971,641	80,051	3,422,115	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,505	0	11,505	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	52,758	0	52,758	0	192.00
194.00	07950	VACANT SPACE	0	2,845	0	2,845	0	194.00
194.01	07951	LEASED SPACE	0	14,636	0	14,636	0	194.01
194.02	07952	FOUNDATION	0	1,431	0	1,431	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	4,270	201.00
202.00		TOTAL (sum lines 118 through 201)	2,370,423	1,054,816	80,051	3,505,290	4,270	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	365,457					5.00
7.00	00700	OPERATION OF PLANT	31,785	176,305				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,656	3,435	826,437			8.00
9.00	00900	HOUSEKEEPING	9,638	273	0	24,230		9.00
10.00	01000	DIETARY	2,243	6,539	0	918	34,262	10.00
11.00	01100	CAFETERIA	4,136	1,829	0	257	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,403	8,830	0	1,240	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,206	4,760	9,396	668	0	14.00
15.00	01500	PHARMACY	12,715	1,574	4,841	221	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,881	3,934	0	552	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,068	37,908	280,547	5,323	31,016	30.00
31.00	03100	INTENSIVE CARE UNIT	7,301	3,649	18,414	512	3,246	31.00
43.00	04300	NURSERY	1,620	948	0	133	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,137	19,070	205,930	2,677	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,877	3,076	0	432	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,685	14,328	0	2,011	0	54.00
56.00	05600	RADIOISOTOPE	46	801	122,335	112	0	56.00
57.00	05700	CT SCAN	3,883	705	0	99	0	57.00
58.00	05800	MRI	3,667	1,860	0	261	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,194	700	12,695	98	0	59.00
60.00	06000	LABORATORY	20,138	5,510	0	773	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,930	0	424	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	13,771	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,616	1,397	0	196	0	65.00
66.00	06600	PHYSICAL THERAPY	5,403	3,616	0	508	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,572	439	15,486	62	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,468	1,692	0	237	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,258	4,875	0	684	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,731	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,634	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,645	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	1,041	677	0	95	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,034	1,850	0	260	0	90.00
91.00	09100	EMERGENCY	19,523	13,468	156,369	1,891	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,748	2,170	0	305	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	361,653	149,913	826,437	20,525	34,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,084	3,651	0	512	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	530	16,740	0	2,350	0	192.00
194.00	07950	VACANT SPACE	29	903	0	127	0	194.00
194.01	07951	LEASED SPACE	147	4,644	0	652	0	194.01
194.02	07952	FOUNDATION	14	454	0	64	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	365,457	176,305	826,437	24,230	34,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,986					11.00
13.00	01300	NURSING ADMINISTRATION	119	49,421				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	402	0	37,480			14.00
15.00	01500	PHARMACY	463	0	0	108,782		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	270,829	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,934	41,496	0	0	160,943	30.00
31.00	03100	INTENSIVE CARE UNIT	456	4,775	0	0	7,822	31.00
43.00	04300	NURSERY	84	3,150	0	0	11,784	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,864	0	0	0	57,884	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	1,026	0	0	56.00
57.00	05700	CT SCAN	211	0	39	0	0	57.00
58.00	05800	MRI	91	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	77	0	0	0	0	59.00
60.00	06000	LABORATORY	709	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	656	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	348	0	0	0	22,141	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	14	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	169	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,213	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	108,782	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	9	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,499	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,048	0	0	0	10,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	56	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,719	49,421	37,480	108,782	270,829	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	267	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,986	49,421	37,480	108,782	270,829	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	766,628	0	766,628		30.00
31.00	03100	INTENSIVE CARE UNIT	108,143	0	108,143		31.00
43.00	04300	NURSERY	20,796	0	20,796		43.00
44.00	04400	SKILLED NURSING FACILITY	2,413	0	2,413		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	700,057	0	700,057		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,032	0	23,032		52.00
53.00	05300	ANESTHESIOLOGY	13,328	0	13,328		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,853	0	110,853		54.00
56.00	05600	RADIOISOTOPE	329,835	0	329,835		56.00
57.00	05700	CT SCAN	8,384	0	8,384		57.00
58.00	05800	MRI	51,003	0	51,003		58.00
59.00	05900	CARDIAC CATHETERIZATION	228,525	0	228,525		59.00
60.00	06000	LABORATORY	123,377	0	123,377		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	43,092	0	43,092		63.00
64.00	06400	INTRAVENOUS THERAPY	18,235	0	18,235		64.00
65.00	06500	RESPIRATORY THERAPY	67,343	0	67,343		65.00
66.00	06600	PHYSICAL THERAPY	37,431	0	37,431		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,658	0	21,658		67.00
68.00	06800	SPEECH PATHOLOGY	9,315	0	9,315		68.00
69.00	06900	ELECTROCARDIOLOGY	26,046	0	26,046		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,335	0	30,335		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,944	0	50,944		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,836	0	40,836		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,427	0	124,427		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03610	SLEEP LAB	15,240	0	15,240		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	54,870	0	54,870		90.00
91.00	09100	EMERGENCY	327,940	0	327,940		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	29,591	0	29,591		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,383,677	0	3,383,677		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,019	0	19,019		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,378	0	72,378		192.00
194.00	07950	VACANT SPACE	3,904	0	3,904		194.00
194.01	07951	LEASED SPACE	20,079	0	20,079		194.01
194.02	07952	FOUNDATION	1,963	0	1,963		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	4,270	0	4,270		201.00
202.00		TOTAL (sum lines 118 through 201)	3,505,290	0	3,505,290		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	365,623					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,782,745				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	0	16,281,956			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,450	19,335	505,529	-9,308,335	36,374,052	5.00
7.00	00700	OPERATION OF PLANT	50,094	0	0	0	3,163,618	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	1,040,691	468,710	0	164,785	8.00
9.00	00900	HOUSEKEEPING	298	18,205	65,584	0	959,250	9.00
10.00	01000	DIETARY	7,143	5,078	585,840	0	223,261	10.00
11.00	01100	CAFETERIA	1,998	0	267,609	0	411,638	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	423,191	0	1,135,013	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	52	170,541	0	717,237	14.00
15.00	01500	PHARMACY	1,720	34,053	349,138	0	1,265,547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	68,220	768,095	0	485,837	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	59,939	2,449,129	0	3,390,899	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	61,787	551,106	0	726,707	31.00
43.00	04300	NURSERY	1,036	3,061	131,316	0	161,193	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	436,793	2,520,414	0	3,596,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	16,905	725,326	0	883,535	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	285,621	1,281,627	0	2,058,808	54.00
56.00	05600	RADIOISOTOPE	875	31	860	0	4,561	56.00
57.00	05700	CT SCAN	770	41,804	294,007	0	386,437	57.00
58.00	05800	MRI	2,032	277,502	119,934	0	365,016	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	86,781	114,799	0	218,345	59.00
60.00	06000	LABORATORY	6,019	50,233	818,575	0	2,004,338	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,225	56,742	0	291,611	63.00
64.00	06400	INTRAVENOUS THERAPY	0	39,984	860,623	0	1,370,699	64.00
65.00	06500	RESPIRATORY THERAPY	1,526	21,798	439,423	0	558,962	65.00
66.00	06600	PHYSICAL THERAPY	3,950	2,257	0	0	537,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	737	0	0	255,964	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	686	21,133	0	146,130	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	40,379	233,301	0	324,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,058,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,451,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,557,150	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	740	14,487	12,927	0	103,609	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	47,527	503,284	0	899,200	90.00
91.00	09100	EMERGENCY	14,713	105,227	1,456,194	0	1,943,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,371	1,347	71,382	0	174,006	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	336,793	2,782,745	16,266,339	-9,308,335	35,995,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	15,617	0	306,980	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	52,758	192.00
194.00	07950	VACANT SPACE	986	0	0	0	2,845	194.00
194.01	07951	LEASED SPACE	5,073	0	0	0	14,636	194.01
194.02	07952	FOUNDATION	496	0	0	0	1,431	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,054,816	80,051	-166,154		9,308,335	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.884983	0.028767	0.000000		0.255906	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,270		365,457	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000262		0.010047	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 7:46 am

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	192,599					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	216,460				8.00
9.00	00900	HOUSEKEEPING	298	0	188,549			9.00
10.00	01000	DIETARY	7,143	0	7,143	31,320		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	26,589	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	9,646	0	263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	2,461	5,200	0	892	14.00
15.00	01500	PHARMACY	1,720	1,268	1,720	0	1,026	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	4,298	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	73,481	41,412	28,353	4,291	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	4,823	3,986	2,967	1,011	31.00
43.00	04300	NURSERY	1,036	0	1,036	0	187	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	53,937	20,832	0	4,134	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	0	3,360	0	1,035	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	0	15,652	0	2,211	54.00
56.00	05600	RADIOISOTOPE	875	32,042	875	0	1	56.00
57.00	05700	CT SCAN	770	0	770	0	469	57.00
58.00	05800	MRI	2,032	0	2,032	0	202	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	3,325	765	0	171	59.00
60.00	06000	LABORATORY	6,019	0	6,019	0	1,572	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	111	0	0	103	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	1,455	64.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	773	65.00
66.00	06600	PHYSICAL THERAPY	3,950	0	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	4,056	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	30	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	0	5,326	0	376	69.00
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	03610	SLEEP LAB	740	0	740	0	20	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	0	2,021	0	3,325	90.00
91.00	09100	EMERGENCY	14,713	40,956	14,713	0	2,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,371	0	2,371	0	125	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	163,769	216,460	159,719	31,320	25,996	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	593	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	18,287	0	0	192.00
194.00	07950	VACANT SPACE	986	0	986	0	0	194.00
194.01	07951	LEASED SPACE	5,073	0	5,073	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,973,207	284,356	1,210,876	473,624	571,028	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.629427	1.313665	6.422076	15.122095	21.476099	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	176,305	826,437	24,230	34,262	11,986	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.915399	3.817966	0.128508	1.093934	0.450788	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/31/2019 7:46 am

		Cost Center Description	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	8,881					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,671,728				14.00
15.00	01500	PHARMACY	0	0	1,557,150			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	29,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,457	0	0	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	858	0	0	839		31.00
43.00	04300	NURSERY	566	0	0	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	155,272	0	0		56.00
57.00	05700	CT SCAN	0	5,840	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,375		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,058,722	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,451,894	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,557,150	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03610	SLEEP LAB	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,881	5,671,728	1,557,150	29,051		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	VACANT SPACE	0	0	0	0		194.00
194.01	07951	LEASED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,692,056	1,063,840	1,659,637	726,433		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	190.525391	0.187569	1.065817	25.005439		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,421	37,480	108,782	270,829		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.564801	0.006608	0.069860	9.322536		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 7:46 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	7,848,791		7,848,791	0	7,848,791	30.00
31.00	03100	INTENSIVE CARE UNIT	1,277,869		1,277,869	0	1,277,869	31.00
43.00	04300	NURSERY	373,928		373,928	0	373,928	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,394,953		5,394,953	0	5,394,953	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,222,758		1,222,758	0	1,222,758	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,056,563		3,056,563	0	3,056,563	54.00
56.00	05600	RADIOISOTOPE	100,635		100,635	0	100,635	56.00
57.00	05700	CT SCAN	517,326		517,326	0	517,326	57.00
58.00	05800	MRI	517,733		517,733	0	517,733	58.00
59.00	05900	CARDIAC CATHETERIZATION	302,956		302,956	0	302,956	59.00
60.00	06000	LABORATORY	2,713,843		2,713,843	0	2,713,843	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	368,594		368,594	0	368,594	63.00
64.00	06400	INTRAVENOUS THERAPY	1,752,717		1,752,717	0	1,752,717	64.00
65.00	06500	RESPIRATORY THERAPY	819,274	0	819,274	0	819,274	65.00
66.00	06600	PHYSICAL THERAPY	782,253	0	782,253	0	782,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,780	0	339,780	0	339,780	67.00
68.00	06800	SPEECH PATHOLOGY	234,161	0	234,161	0	234,161	68.00
69.00	06900	ELECTROCARDIOLOGY	559,357		559,357	0	559,357	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,415,191		4,415,191	0	4,415,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,539,247		3,539,247	0	3,539,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,615,271		3,615,271	0	3,615,271	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03610	SLEEP LAB	150,571		150,571	0	150,571	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,255,390		1,255,390	4,519	1,259,909	90.00
91.00	09100	EMERGENCY	2,969,690		2,969,690	0	2,969,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,595,093		1,595,093		1,595,093	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	285,359		285,359		285,359	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	46,009,303	0	46,009,303	4,519	46,013,822	200.00
201.00		Less Observation Beds	1,595,093		1,595,093		1,595,093	201.00
202.00		Total (see instructions)	44,414,210	0	44,414,210	4,519	44,418,729	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 7:46 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	7,379,914		7,379,914			30.00
31.00	03100	INTENSIVE CARE UNIT	5,713,253		5,713,253			31.00
43.00	04300	NURSERY	442,771		442,771			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,433,045	41,545,321	51,978,366	0.103792	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,479,262	0	1,479,262	0.826600	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,305,225	19,440,227	21,745,452	0.140561	0.000000	54.00
56.00	05600	RADIOISOTOPE	241,784	3,845,635	4,087,419	0.024621	0.000000	56.00
57.00	05700	CT SCAN	5,011,246	30,930,944	35,942,190	0.014393	0.000000	57.00
58.00	05800	MRI	524,582	7,232,555	7,757,137	0.066743	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,542	1,642,681	1,722,223	0.175910	0.000000	59.00
60.00	06000	LABORATORY	3,987,995	8,198,947	12,186,942	0.222684	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	531,486	619,031	1,150,517	0.320372	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,193,470	3,859,125	5,052,595	0.346894	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,873,956	792,052	5,666,008	0.144595	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,171,959	2,238,111	3,410,070	0.229395	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,987	141,204	449,191	0.756427	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	121,826	323,163	444,989	0.526218	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,528,967	7,016,041	9,545,008	0.058602	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,102,265	4,805,501	8,907,766	0.495656	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,984,913	3,016,716	6,001,629	0.589714	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,543,660	8,174,133	14,717,793	0.245639	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03610	SLEEP LAB	2,751	281,126	283,877	0.530409	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	93,291	5,369,020	5,462,311	0.229828	0.000000	90.00
91.00	09100	EMERGENCY	4,413,356	29,949,397	34,362,753	0.086422	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	408,388	1,939,806	2,348,194	0.679285	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	286,495	286,495			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	66,876,894	181,647,231	248,524,125			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,876,894	181,647,231	248,524,125			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/31/2019 7:46 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.103792	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.826600	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140561	54.00
56.00	05600	RADIOISOTOPE	0.024621	56.00
57.00	05700	CT SCAN	0.014393	57.00
58.00	05800	MRI	0.066743	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.175910	59.00
60.00	06000	LABORATORY	0.222684	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320372	63.00
64.00	06400	INTRAVENOUS THERAPY	0.346894	64.00
65.00	06500	RESPIRATORY THERAPY	0.144595	65.00
66.00	06600	PHYSICAL THERAPY	0.229395	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.756427	67.00
68.00	06800	SPEECH PATHOLOGY	0.526218	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058602	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.495656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.589714	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.245639	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03610	SLEEP LAB	0.530409	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.230655	90.00
91.00	09100	EMERGENCY	0.086422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.679285	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/31/2019 7:46 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	766,628	0	766,628	9,359	81.91	30.00
31.00	INTENSIVE CARE UNIT	108,143		108,143	858	126.04	31.00
43.00	NURSERY	20,796		20,796	566	36.74	43.00
44.00	SKILLED NURSING FACILITY	2,413		2,413	0	0.00	44.00
200.00	Total (lines 30 through 199)	897,980		897,980	10,783		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	3,891	318,712				30.00
31.00	INTENSIVE CARE UNIT	389	49,030				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	4,280	367,742				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/31/2019 7:46 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	700,057	51,978,366	0.013468	4,141,654	55,780	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,032	1,479,262	0.015570	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,328	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,853	21,745,452	0.005098	1,204,392	6,140	54.00
56.00	05600	RADIOISOTOPE	329,835	4,087,419	0.080695	161,962	13,070	56.00
57.00	05700	CT SCAN	8,384	35,942,190	0.000233	2,531,280	590	57.00
58.00	05800	MRI	51,003	7,757,137	0.006575	194,562	1,279	58.00
59.00	05900	CARDIAC CATHETERIZATION	228,525	1,722,223	0.132692	45,039	5,976	59.00
60.00	06000	LABORATORY	123,377	12,186,942	0.010124	1,965,469	19,898	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	43,092	1,150,517	0.037454	223,734	8,380	63.00
64.00	06400	INTRAVENOUS THERAPY	18,235	5,052,595	0.003609	579,632	2,092	64.00
65.00	06500	RESPIRATORY THERAPY	67,343	5,666,008	0.011885	1,352,749	16,077	65.00
66.00	06600	PHYSICAL THERAPY	37,431	3,410,070	0.010977	651,726	7,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,658	449,191	0.048216	158,799	7,657	67.00
68.00	06800	SPEECH PATHOLOGY	9,315	444,989	0.020933	63,433	1,328	68.00
69.00	06900	ELECTROCARDIOLOGY	26,046	9,545,008	0.002729	1,489,317	4,064	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,335	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,944	8,907,766	0.005719	2,310,233	13,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,836	6,001,629	0.006804	1,896,443	12,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,427	14,717,793	0.008454	3,030,746	25,622	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03610	SLEEP LAB	15,240	283,877	0.053685	2,566	138	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,870	5,462,311	0.010045	65,374	657	90.00
91.00	09100	EMERGENCY	327,940	34,362,753	0.009543	2,221,527	21,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	155,801	2,348,194	0.066349	229,796	15,247	92.00
200.00		Total (lines 50 through 199)	2,611,907	234,701,692		24,520,433	238,464	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/31/2019 7:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	9,359	0.00	3,891	30.00
31.00	03100	INTENSIVE CARE UNIT		0	858	0.00	389	31.00
43.00	04300	NURSERY		0	566	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	10,783		4,280	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 7:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/31/2019 7:46 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	51,978,366	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,479,262	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,745,452	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,087,419	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	35,942,190	0.000000	57.00
58.00	05800	MRI	0	0	0	7,757,137	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,722,223	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	12,186,942	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,150,517	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,052,595	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,666,008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,410,070	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	449,191	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,989	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,545,008	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,907,766	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,001,629	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,717,793	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03610	SLEEP LAB	0	0	0	283,877	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,462,311	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	34,362,753	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,348,194	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	234,701,692		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/31/2019 7:46 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	4,141,654	0	13,329,059	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,204,392	0	5,018,789	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	161,962	0	1,278,465	0	56.00
57.00	05700	CT SCAN	0.000000	2,531,280	0	9,767,367	0	57.00
58.00	05800	MRI	0.000000	194,562	0	2,314,272	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	45,039	0	278,469	0	59.00
60.00	06000	LABORATORY	0.000000	1,965,469	0	1,269,088	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	223,734	0	193,066	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	579,632	0	918,069	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,352,749	0	61,743	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	651,726	0	64,348	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	158,799	0	24,456	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	63,433	0	5,329	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,489,317	0	2,367,507	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,310,233	0	1,056,971	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,896,443	0	1,494,111	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,030,746	0	2,499,894	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0.000000	2,566	0	85,636	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	65,374	0	1,072,499	0	90.00
91.00	09100	EMERGENCY	0.000000	2,221,527	0	5,398,758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	229,796	0	463,633	0	92.00
200.00		Total (lines 50 through 199)		24,520,433	0	48,961,529	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/31/2019 7:46 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	0.103792	13,329,059	0	0	1,383,450	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.826600	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140561	5,018,789	0	0	705,446	54.00
56.00	05600	RADIOISOTOPE	0.024621	1,278,465	0	0	31,477	56.00
57.00	05700	CT SCAN	0.014393	9,767,367	0	0	140,582	57.00
58.00	05800	MRI	0.066743	2,314,272	0	0	154,461	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.175910	278,469	0	0	48,985	59.00
60.00	06000	LABORATORY	0.222684	1,269,088	0	0	282,606	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320372	193,066	0	0	61,853	63.00
64.00	06400	INTRAVENOUS THERAPY	0.346894	918,069	0	0	318,473	64.00
65.00	06500	RESPIRATORY THERAPY	0.144595	61,743	0	0	8,928	65.00
66.00	06600	PHYSICAL THERAPY	0.229395	64,348	0	0	14,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.756427	24,456	0	0	18,499	67.00
68.00	06800	SPEECH PATHOLOGY	0.526218	5,329	0	0	2,804	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058602	2,367,507	0	0	138,741	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.495656	1,056,971	0	0	523,894	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.589714	1,494,111	0	0	881,098	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.245639	2,499,894	0	7,042	614,071	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0.530409	85,636	0	0	45,422	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.229828	1,072,499	0	0	246,490	90.00
91.00	09100	EMERGENCY	0.086422	5,398,758	0	0	466,571	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.679285	463,633	0	0	314,939	92.00
200.00		Subtotal (see instructions)		48,961,529	0	7,042	6,403,551	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		48,961,529	0	7,042	6,403,551	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/31/2019 7:46 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
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	1,730	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	1,730	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,730	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 7:46 am

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	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)	9,359	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,359	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)	7,457	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)	3,891	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)	7,848,791	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)	7,848,791	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)	7,848,791	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)	838.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,263,148	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,263,148	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 7:46 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,277,869	858	1,489.36	389	579,361	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)	5,329,235	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,171,744	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)	367,742	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	238,464	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	606,206	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,565,538	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,902	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	838.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,595,093	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/31/2019 7:46 am

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	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	766,628	7,848,791	0.097675	1,595,093	155,801	90.00
91.00	Nursing School cost	0	7,848,791	0.000000	1,595,093	0	91.00
92.00	Allied health cost	0	7,848,791	0.000000	1,595,093	0	92.00
93.00	All other Medical Education	0	7,848,791	0.000000	1,595,093	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/31/2019 7:46 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,914,336		30.00
31.00	03100	INTENSIVE CARE UNIT		3,229,124		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.103792	4,141,654	429,871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.826600	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140561	1,204,392	169,291	54.00
56.00	05600	RADIOISOTOPE	0.024621	161,962	3,988	56.00
57.00	05700	CT SCAN	0.014393	2,531,280	36,433	57.00
58.00	05800	MRI	0.066743	194,562	12,986	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.175910	45,039	7,923	59.00
60.00	06000	LABORATORY	0.222684	1,965,469	437,678	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320372	223,734	71,678	63.00
64.00	06400	INTRAVENOUS THERAPY	0.346894	579,632	201,071	64.00
65.00	06500	RESPIRATORY THERAPY	0.144595	1,352,749	195,601	65.00
66.00	06600	PHYSICAL THERAPY	0.229395	651,726	149,503	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.756427	158,799	120,120	67.00
68.00	06800	SPEECH PATHOLOGY	0.526218	63,433	33,380	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058602	1,489,317	87,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.495656	2,310,233	1,145,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.589714	1,896,443	1,118,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.245639	3,030,746	744,469	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03610	SLEEP LAB	0.530409	2,566	1,361	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230655	65,374	15,079	90.00
91.00	09100	EMERGENCY	0.086422	2,221,527	191,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.679285	229,796	156,097	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		24,520,433	5,329,235	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)		24,520,433		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 7:46 am
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		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)	5,758,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,244,048	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)	198,609	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)	101.79	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)	2.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.83	31.00
32.00	Sum of lines 30 and 31	20.37	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.02	33.00
34.00	Disproportionate share adjustment (see instructions)	120,438	34.00

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		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)	469,205	513,051	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	350,940	129,317	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	480,257		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)	8,801,834		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)	8,801,834	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	689,014	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)	9,490,848	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,490,848	61.00
62.00	Deductibles billed to program beneficiaries	996,768	62.00
63.00	Coinsurance billed to program beneficiaries	4,020	63.00
64.00	Allowable bad debts (see instructions)	67,976	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	44,184	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	67,976	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,534,244	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)	7,042	70.93
70.94	HRR adjustment amount (see instructions)	-124,983	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 7:46 am
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		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)		93,730	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,322,573	71.00
71.01	Sequestration adjustment (see instructions)		166,451	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		8,021,399	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)		134,723	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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2019 7:46 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	
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	5,758,482	0	5,758,482		5,758,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,244,048	0		2,244,048	2,244,048	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	198,609	0	69,383	129,226	198,609	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	0.0602	0.0602	0.0602	0.0602		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	120,438	0	86,665	33,773	120,438	11.00
11.01	Uncompensated care payments	36.00	480,257	0	350,940	129,317	480,257	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	8,801,834	0	6,265,470	2,536,364	8,801,834	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	8,801,834	0	6,265,470	2,536,364	8,801,834	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	689,014	0	490,325	198,689	689,014	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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2019 7:46 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	6,755,795	2,735,053	9,490,848	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	646,559	0	465,381	181,178	646,559	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	15,235	0	5,352	9,883	15,235	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	0.0421	0.0421	0.0421	0.0421		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	27,220	0	19,592	7,628	27,220	25.00
26.00	Total prospective capital payments (see instructions)	12.00	689,014	0	490,325	198,689	689,014	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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2019 7:46 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,758,482	5,758,482		5,758,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,244,048		2,244,048	2,244,048	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	198,609	69,383	129,226	198,609	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	0.0602	0.0602	0.0602		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	120,438	86,665	33,773	120,438	11.00
11.01	Uncompensated care payments	36.00	480,257	350,940	129,317	480,257	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	8,801,834	6,265,470	2,536,364	8,801,834	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	8,801,834	6,265,470	2,536,364	8,801,834	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	689,014	490,325	198,689	689,014	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			6,755,795	2,735,053	9,490,848	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2019 7:46 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	646,559	465,381	181,178	646,559	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	15,235	5,352	9,883	15,235	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	0.0421	0.0421	0.0421		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	27,220	19,592	7,628	27,220	25.00
26.00	Total prospective capital payments (see instructions)	12.00	689,014	490,325	198,689	689,014	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	7,042	-1,692	8,734	7,042	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	-124,983	-82,346	-42,637	-124,983	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		66,718	27,012	93,730	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/31/2019 7:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,730	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,403,551	2.00
3.00	OPPS payments	6,380,510	3.00
4.00	Outlier payment (see instructions)	20,326	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,730	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,042	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	7,042	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	7,042	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,312	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,730	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)	6,400,836	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	3,779	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,306,558	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)	5,092,229	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)	5,092,229	30.00
31.00	Primary payer payments	2,225	31.00
32.00	Subtotal (line 30 minus line 31)	5,090,004	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)	95,802	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	62,271	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	95,802	36.00
37.00	Subtotal (see instructions)	5,152,275	37.00
38.00	MSP-LCC reconciliation amount from PS&R	122	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)	5,152,153	40.00
40.01	Sequestration adjustment (see instructions)	103,043	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,991,721	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	57,389	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2019 7:46 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,021,399		4,991,721	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)		8,021,399		4,991,721	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		134,723		57,389	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,156,122		5,049,110	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/31/2019 7:46 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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/31/2019 7:46 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	5,138,122	0	0	0	1.00
2.00	Temporary investments	2,511,106	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,826,895	0	0	0	4.00
5.00	Other receivable	4,242,467	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,380,045	0	0	0	7.00
8.00	Prepaid expenses	338,540	0	0	0	8.00
9.00	Other current assets	245,312	0	0	0	9.00
10.00	Due from other funds	7,416,908	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	33,099,395	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,250,000	0	0	0	12.00
13.00	Land improvements	180,968	0	0	0	13.00
14.00	Accumulated depreciation	-60,039	0	0	0	14.00
15.00	Buildings	10,195,182	0	0	0	15.00
16.00	Accumulated depreciation	-197,398	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	6,324,268	0	0	0	19.00
20.00	Accumulated depreciation	-1,212,093	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	5,573,167	0	0	0	23.00
24.00	Accumulated depreciation	-1,286,717	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)	21,767,338	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	9,132,516	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,132,516	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,999,249	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,651,768	0	0	0	37.00
38.00	Salaries, wages, and fees payable	890,190	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	18,897,919	0	0	0	43.00
44.00	Other current liabilities	4,756,565	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,196,442	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	23,375,988	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,375,988	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	50,572,430	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,426,819				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)	13,426,819	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,999,249	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/31/2019 7:46 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		12,652,392		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,125,813				2.00
3.00	Total (sum of line 1 and line 2)		13,778,205		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,778,205		0		11.00
12.00	CHANGE IN UNRESTRICTED FUND BALANCE	351,386		0		0	12.00
13.00	ROUNDING	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		351,386		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,426,819		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	CHANGE IN UNRESTRICTED FUND BALANCE		0			12.00
13.00	ROUNDING		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: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2019 7:46 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	13,723,965		13,723,965	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,723,965		13,723,965	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,418,327		2,418,327	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)	2,418,327		2,418,327	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,142,292		16,142,292	17.00
18.00	Ancillary services	51,510,745	0	51,510,745	18.00
19.00	Outpatient services	0	183,805,039	183,805,039	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		286,495	286,495	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)	67,653,037	184,091,534	251,744,571	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,569,228		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		41,569,228		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0120 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/31/2019 7:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	251,744,571	1.00
2.00	Less contractual allowances and discounts on patients' accounts	194,486,532	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,258,039	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,569,228	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,688,811	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	192,666	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	328,190	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 PEKIN & HOME OFFICE REVENUE	725,980	24.00
25.00	Total other income (sum of lines 6-24)	1,246,836	25.00
26.00	Total (line 5 plus line 25)	16,935,647	26.00
27.00	HOME OFFICE EXPENSES	15,809,834	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	15,809,834	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,125,813	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H | Date/Time Prepared: 5/31/2019 7:46 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		15,340	15,340	1.00
2.00	Capital Related - Movable Equipment			0		3,093	3,093	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	5,573	5,573	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	12,972	0	2,350	889	16,084	32,295	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	50,824	0	0	0	0	50,824	6.00
7.00	Physical Therapy	0	0	0	39,053	0	39,053	7.00
8.00	Occupational Therapy	0	0	0	11,683	0	11,683	8.00
9.00	Speech Pathology	0	0	0	1,428	0	1,428	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	7,586	0	0	0	0	7,586	11.00
12.00	Supplies (see instructions)	0	0	0	252	1,501	1,753	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	71,382	0	2,350	53,305	41,591	168,628	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	15,340	0	15,340			1.00
2.00	Capital Related - Movable Equipment	0	3,093	0	3,093			2.00
3.00	Plant Operation & Maintenance	0	5,573	0	5,573			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	32,295	0	32,295			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	50,824	0	50,824			6.00
7.00	Physical Therapy	0	39,053	0	39,053			7.00
8.00	Occupational Therapy	0	11,683	0	11,683			8.00
9.00	Speech Pathology	0	1,428	0	1,428			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	7,586	0	7,586			11.00
12.00	Supplies (see instructions)	-1,501	252	0	252			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-1,501	167,127	0	167,127			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 5/31/2019 7:46 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	15,340	15,340				0	1.00
2.00	Capital Related - Movable Equipment	3,093		3,093			0	2.00
3.00	Plant Operation & Maintenance	5,573	0	0	5,573		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	32,295	15,340	3,093	5,573	0	56,301	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	50,824	0	0	0	0	50,824	6.00
7.00	Physical Therapy	39,053	0	0	0	0	39,053	7.00
8.00	Occupational Therapy	11,683	0	0	0	0	11,683	8.00
9.00	Speech Pathology	1,428	0	0	0	0	1,428	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	7,586	0	0	0	0	7,586	11.00
12.00	Supplies (see instructions)	252	0	0	0	0	252	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	167,127	15,340	3,093	5,573	0	167,127	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	56,301		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	25,820	76,644	6.00
7.00	Physical Therapy	19,839	58,892	7.00
8.00	Occupational Therapy	5,935	17,618	8.00
9.00	Speech Pathology	725	2,153	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	3,854	11,440	11.00
12.00	Supplies (see instructions)	128	380	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		167,127	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II | Date/Time Prepared: 5/31/2019 7:46 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	6,840				0		1.00
2.00	Capital Related - Movable Equipment		3,093			0		2.00
3.00	Plant Operation & Maintenance	0	0	5,573		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	6,840	3,093	5,573	0	-56,301	110,826	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	50,824	6.00
7.00	Physical Therapy	0	0	0	0	0	39,053	7.00
8.00	Occupational Therapy	0	0	0	0	0	11,683	8.00
9.00	Speech Pathology	0	0	0	0	0	1,428	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	7,586	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	252	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	6,840	3,093	5,573	0	-56,301	110,826	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	15,340	3,093	5,573	0		56,301	25.00
26.00	Unit Cost Multiplier	2.242690	1.000000	1.000000	0.000000		0.508013	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0120 HHA CCN: 14-7057

Period: From 01/01/2018 To 12/31/2018

Worksheet H-2 Part I Date/Time Prepared: 5/31/2019 7:46 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	6,840	39	0	6,879	1,760	1.00
2.00	Skilled Nursing Care	76,644	0	0	0	76,644	19,613	2.00
3.00	Physical Therapy	58,892	0	0	0	58,892	15,071	3.00
4.00	Occupational Therapy	17,618	0	0	0	17,618	4,509	4.00
5.00	Speech Pathology	2,153	0	0	0	2,153	551	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	11,440	0	0	0	11,440	2,928	7.00
8.00	Supplies (see instructions)	380	0	0	0	380	97	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	167,127	6,840	39	0	174,006	44,529	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	48,912	0	15,227	0	2,685	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	48,912	0	15,227	0	2,685	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I Date/Time Prepared: 5/31/2019 7:46 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	75,463	0	75,463	1.00
2.00	Skilled Nursing Care	0	0	0	96,257	0	96,257	2.00
3.00	Physical Therapy	0	0	0	73,963	0	73,963	3.00
4.00	Occupational Therapy	0	0	0	22,127	0	22,127	4.00
5.00	Speech Pathology	0	0	0	2,704	0	2,704	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	14,368	0	14,368	7.00
8.00	Supplies (see instructions)	0	0	0	477	0	477	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	285,359	0	285,359	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	34,607	130,864					2.00
3.00	Physical Therapy	26,592	100,555					3.00
4.00	Occupational Therapy	7,955	30,082					4.00
5.00	Speech Pathology	972	3,676					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	5,166	19,534					7.00
8.00	Supplies (see instructions)	171	648					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	75,463	285,359					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.359526						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0120 HHA CCN: 14-7057

Period: From 01/01/2018 To 12/31/2018

Worksheet H-2 Part II Date/Time Prepared: 5/31/2019 7:46 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	2,371	1,347	71,382	0	6,879	2,371	1.00
2.00	Skilled Nursing Care	0	0	0	0	76,644	0	2.00
3.00	Physical Therapy	0	0	0	0	58,892	0	3.00
4.00	Occupational Therapy	0	0	0	0	17,618	0	4.00
5.00	Speech Pathology	0	0	0	0	2,153	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	11,440	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	380	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,371	1,347	71,382		174,006	2,371	20.00
21.00	Total cost to be allocated	6,840	39	0		44,529	48,912	21.00
22.00	Unit cost multiplier	2.884859	0.028953	0.000000		0.255905	20.629270	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,371	0	125	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,371	0	125	0	0	20.00
21.00	Total cost to be allocated	0	15,227	0	2,685	0	0	21.00
22.00	Unit cost multiplier	0.000000	6.422185	0.000000	21.480000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0120
HHA CCN: 14-7057

Period:
From 01/01/2018
To 12/31/2018

Worksheet H-2
Part II
Date/Time Prepared:
5/31/2019 7:46 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/31/2019 7:46 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	130,864		130,864	482	271.50	1.00
2.00	Physical Therapy	3.00	100,555	0	100,555	565	177.97	2.00
3.00	Occupational Therapy	4.00	30,082	0	30,082	124	242.60	3.00
4.00	Speech Pathology	5.00	3,676	0	3,676	19	193.47	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	19,534		19,534	35	558.11	6.00
7.00	Total (sum of lines 1-6)		284,711	0	284,711	1,225		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	0	297			8.00
8.01	Skilled Nursing Care		99914	0	5			8.01
9.00	Physical Therapy		37900	0	415			9.00
9.01	Physical Therapy		99914	0	18			9.01
10.00	Occupational Therapy		37900	0	95			10.00
10.01	Occupational Therapy		99914	0	6			10.01
11.00	Speech Pathology		37900	0	19			11.00
11.01	Speech Pathology		99914	0	0			11.01
12.00	Medical Social Services		37900	0	0			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		37900	0	28			13.00
13.01	Home Health Aide		99914	0	0			13.01
14.00	Total (sum of lines 8-13)			0	883			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	648	0	648	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	302		0	81,993		1.00
2.00	Physical Therapy	0	433		0	77,061		2.00
3.00	Occupational Therapy	0	101		0	24,503		3.00
4.00	Speech Pathology	0	19		0	3,676		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	28		0	15,627		6.00
7.00	Total (sum of lines 1-6)	0	883		0	202,860		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 5/31/2019 7:46 am

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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	128	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	81,993		1.00
2.00	Physical Therapy	77,061		2.00
3.00	Occupational Therapy	24,503		3.00
4.00	Speech Pathology	3,676		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	15,627		6.00
7.00	Total (sum of lines 1-6)	202,860		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part II | Date/Time Prepared: 5/31/2019 7:46 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.229395	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.756427	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.526218	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.495656	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.245639	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/31/2019 7:46 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	163,923	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	1,949	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,963	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	169,835	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	169,835	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	169,835	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	169,835	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	169,835	31.00
31.01	Sequestration adjustment (see instructions)	0	3,397	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	166,439	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-5 | Date/Time Prepared: 5/31/2019 7:46 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		166,439	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		166,439	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		166,438	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0120	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/31/2019 7:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	646,559	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	15,235	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)	24.81	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)	2.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	17.83	8.00
9.00	Sum of lines 7 and 8	20.37	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.21	10.00
11.00	Disproportionate share adjustment (see instructions)	27,220	11.00
12.00	Total prospective capital payments (see instructions)	689,014	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